



**USAID**  
FROM THE AMERICAN PEOPLE

**Philippines**  
**HIV/AIDS Strategic Plan, 2002-2006**

Submitted by

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## **ABBREVIATIONS**

AIDS	Acquired immunodeficiency syndrome
ASEP	AIDS Surveillance and Education Project
BCC	Behavior Change Communication
BHW	Barangay health worker
BIDLISIW	Bidlisiw Foundation (NGO)
BSS	Behavioral Surveillance Survey
CDC	Centers for Disease Control and Prevention
CHO	City Health Office
CHOW	Community health outreach worker
COPE	Community outreach and peer education
CSM	Contraceptive social marketing
DILG	Department of Interior and Local Government
DKT	DKT International
DOH	Department of Health
FFSW	Female freelance sex worker
FHI	Family Health International
FP	Family planning
FPOP	Family Planning Association of the Philippines
FreeLAVA	Free Legal Assistance Volunteers Association, Inc.
GenSan	General Santos City
GOP	Government of the Philippines
HIV	Human immunodeficiency virus
HSS	HIV Sentinel Surveillance
IDSCP	Infectious Disease Surveillance and Control Project
IDU	Injecting drug user
IEC	Information, education, and communication
IPPF	International Planned Parenthood Federation
IR	Intermediate result
JICA	Japan International Cooperation Agency
KfW	Kreditanstalt fur Wiederaufbau (German aid agency)
LGU	Local Government Unit
LPP	Local Government Unit Performance Project
MARG	Most at-risk group(s)
MGP	Matching Grant Program
MSH	Management Sciences for Health
MSM	Men who have sex with men
MSW	Male sex workers
NASPCP	National AIDS/STD Prevention and Control Program
NCDPC	National Center for Disease Prevention and Control
NEC	National Epidemiology Center
NGO	Nongovernmental organization
NHSSS	National HIV/AIDS Sentinel Surveillance System

PATH	Program for Appropriate Technology in Health
PHONSUP	Philippine NGO Support Program
PLWHA	People living with HIV/AIDS
PMP	Project monitoring program
PNAC	Philippines National AIDS Council
PNP	Philippine National Police
POCOMON	Policy Compliance Monitoring
RA	Republic Act
RFA	Request for award
RFP	Request for proposal
RFSW	Registered female sex worker
RH	Reproductive health
RHU	Rural Health Unit
SHC	Social Hygiene Clinic
SO	Strategic objective
SOW	Scope (or Statement) of work
SpO	Special objective
STI	Sexually transmitted infection
TFGI	The Futures Group International
T/S, Triple S	Solución Sekretong Sakit
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Education Fund
USAID	United States Agency for International Development
USPF	The University of Southern Philippines Foundation
VCT	Voluntary counseling and testing
WHO/WPRO	World Health Organization/Western Pacific Regional Office

## EXECUTIVE SUMMARY

### **Background.**

UNAIDS categorizes the Philippines as a low HIV-prevalence country<sup>1</sup>. The rate of increase in HIV/AIDS is called “low and slow.” In February of 2002, for example, only three new AIDS cases were reported. Only one reported death was reported between December and February; nevertheless, serological surveillance shows that the infection is already present in the main cities of the main islands of Luzon, Visayas, and Mindanao.

The dominant at-risk populations are classified as: registered commercial female sex workers, freelance female sex workers, men who have sex with men, male sex workers, injecting drug users, and male clients of sexually transmitted infection clinics. The principal risk behaviors are unprotected sex, low use of condoms, high rates of sexually transmitted infections, poor sexually transmitted infection health-seeking behavior and lack of knowledge. Although there is high awareness among these risk groups of what HIV is and how to prevent it, behavior lags far behind.

The Government of the Philippines has responded aggressively to the HIV/AIDS threat and adopted a dual strategy of surveillance and preventive education. USAID has been a strong supporter of the Government’s HIV/AIDS efforts, both in surveillance and preventive education. USAID’s most significant contribution has been the AIDS Surveillance and Education Project, which has been in operation for almost a decade.

While the AIDS Surveillance and Education Project evaluation conducted in 2001 showed both the surveillance and education/policy components of the project had been successful, it also showed critical gaps that needed to be filled in such areas as surveillance, education, policies, and advocacy. These gaps, which should be addressed over the next four years, needed to be filled especially with respect to the underserved, most at-risk freelance female sex workers, men who have sex with men, and injecting drug users populations in the 10 AIDS Surveillance and Education Project sites.

**Proposed Strategy.** The Strategic Plan places HIV/AIDS support within the Mission’s Population, Health and Nutrition Strategic Objective. It attempts to respond to the priority needs while remaining within a budget roughly equivalent to the current budget. It proposes cost-effective interventions designed to be sustained by the local government units prior to the end of project funding. If this strategy were accepted, the principal objectives under the new strategy are as follows:

- **Keep HIV/AIDS infections low and slow.** The major objective of this strategy is to avoid any increase in HIV/AIDS infections, as has already occurred in several countries in the region.
- **Prevent infections among the most at-risk groups.** Once they become infected the disease can spread rapidly. The four highest priority groups are registered commercial female sex workers, freelance female sex workers, MSM, including male sex workers, and injecting drug users.

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<sup>1</sup> Low-level epidemic is defined by UNAIDS/WHO as “HIV prevalence has not constantly exceeded five percent in any defined sub-populations”, *Guidelines for Second Generation Surveillance*, June 2000.

- **Integrate sustainable HIV/AIDS interventions into local government unit and nongovernmental organization programs.** This should be done so these USAID-funded activities are continued after the strategy ends in 2006.

**Interventions.** The principal interventions would be: 1) strengthen HIV/AIDS surveillance systems; 2) develop plans for sustaining local government units support; 3) strengthen nongovernmental organizations to identify and educate the most at-risk groups; and 4) create a positive policy environment to remove obstacles to implementation and continuation.

**Surveillance.** *Improve HIV/AIDS Surveillance, especially among the most at-risk populations.* Although the current surveillance system is operating relatively well, the methodology needs to be strengthened, additional data need to be collected, and the HIV Sentinel Surveillance and Behavior Surveillance System must be expanded to provide adequate and accurate information on the most at-risk groups, especially men who have sex with men and injecting drug users. Activities should include:

- Extending surveillance and education to selected areas contiguous to AIDS Surveillance and Education Project sites;
- Expanding HIV Sentinel Surveillance of female freelance sex workers, men who have sex with men, and injecting drug users in current sites and contiguous areas;
- Strengthening nongovernmental organization capacity to identify most at-risk groups;
- Conducting one-time studies of other high-risk groups;
- Integrating HIV Sentinel Surveillance with infectious disease surveillance within the National Epidemiology Center and local government units;
- Strengthening Behavior Surveillance System methodology; and
- Continuing Behavior Surveillance System support until transition to local government units.

**Sustainability.** *Facilitate planning for local government units to sustain HIV/AIDS preventive education and health services for the most at-risk populations.* Most of the current AIDS Surveillance and Education Project local government units are willing to take over the serological surveillance, but they are not yet convinced of the need to continue the behavioral surveillance component, nor to monitor female freelance sex workers, men who have sex with men, and injecting drug users groups. Activities should include:

- Developing a strategy to sustain prevention activities;
- Developing plans for local government units to absorb prevention activities; and
- Piloting local government units' contracts with nongovernmental organizations in prevention activities.

**Nongovernmental Organization Capacity Development.** *Strengthen nongovernmental organization capacity to identify and reduce the threat of HIV/AIDS among the most at-risk groups.* This is the largest component of the strategy and the most essential. Local nongovernmental organizations will be responsible for most at-risk groups casefinding, as well as preventive education and advocacy. Activities should include:

- Identifying nongovernmental organizations capable of reaching the most at-risk groups (freelance female sex workers, men who have sex with men, and injecting drug users), and providing them with institutional capacity building;
- Providing support for nongovernmental organization operations and implementation;

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- Developing the capacity of the nongovernmental organizations to identify and recruit the most at-risk groups for voluntary counseling and testing;
- Developing the capacity of the nongovernmental organizations to develop and disseminate behavior change communication messages and materials to reduce unprotected sex and harmful practices;
- Identifying and support implementation of innovative models for improving behavior change communication for the most at-risk populations;
- Linking nongovernmental organization work among the most-at-risk populations to condom social marketing activities;
- Building nongovernmental organization capacity to provide information, education, and communication in the areas of sexually transmitted infections, family planning, and reproductive health to at-risk groups, including referral to local government units and barangay health units;
- Strengthening nongovernmental organization capacity to be an advocate for policy change and funding; and
- Supporting nongovernmental organizations and nongovernmental organization government partner participation in regional/global conferences and HIV-focused events.

**Policy and Advocacy.** *Assist the Philippines National AIDS Commission using the mandate of RA 8504,<sup>2</sup> to further strengthen implementation and local interpretation of national policies supportive of financing and delivery of HIV/AIDS prevention at local levels.* Progress has been made by the Philippines National AIDS Commission to mobilize support for HIV/AIDS prevention, but significant obstacles need to be overcome. Convincing local government units to accept a comprehensive approach to HIV prevention, as developed by AIDS Surveillance and Education Project, is one. Ensuring adequate supplies and distribution of condoms is another. Activities to assist the Philippines National AIDS Commission in mobilizing its partner agencies should include:

- Planning and conducting an advocacy campaign for adoption of the AIDS Surveillance and Education Project package by local government units;
- Developing a national plan for condom supply security;
- Developing a strategy on sexually transmitted infection diagnosis and treatment;
- Developing a national policy for voluntary counseling and testing for HIV/AIDS; and
- Developing a government directive on harm reduction.

**Assumptions and Cross-Cutting Issues.** Three critical assumptions are discussed in this document: continuation of low prevalence; local government unit commitment; and national Department of Health capacity. Five significant issues are also examined: youth; participation of people living with HIV/AIDS; gender and sexuality; drug use and unsafe sexual behavior; and stigma reduction and human rights.

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<sup>2</sup> The Philippine AIDS Prevention and Control Act of 1998 (RA 8504)

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**Procurement and Budget.** Three procurement options are examined. The procurement options are: Request for Proposals or Request for Award on HIV/AIDS; buy-ins to one or more centrally funded projects; and/or a combined Local Government Unit/HIV/AIDS Request for Proposal/Request for Award. Five criteria should be taken into account in deciding which options to utilize: quality of technical assistance, cost, management burden, control, flexibility, and integration. The design team recommends buy-ins to centrally funded projects.

The four-year budget proposed is just under \$6 million (\$1.5 million/year) with a phase-down period in the last year. The estimated budgets for the four interventions and project staff are summarized below:

<b>Summary</b>	<b>FY 1*</b>	<b>FY 2</b>	<b>FY 3</b>	<b>FY 4</b>	<b>Total</b>	<b>Percent</b>
IR 1.1: Surveillance	404,000	121,000	69,000	0	594,000	10.0
IR 1.2: Sustainability	476,000	69,000	272,000	69,000	889,000	15.0
IR 1.3: NGO capacity	825,000	735,000	766,000	342,000	2,668,000	45.0
IR 4.2: Policy/Advocacy	248,000	399,000	469,000	372,000	1,488,000	25.0
Project Management	65,000	71,000	77,000	84,000	297,000	5.0
<b>Total</b>	<b>2,018,000</b>	<b>1,395,000</b>	<b>1,653,000</b>	<b>867,000</b>	<b>5,933,000</b>	<b>100</b>

\*FY = fiscal year

## **I. SITUATIONAL ANALYSIS**

### **A. HIV/AIDS in the Philippines**

The first known HIV/AIDS fatality in the Philippines occurred in 1984, when a foreign national died of AIDS-related pneumonia. By February 2002, some 1,633 HIV cases had been reported. According to the Department of Health (DOH), heterosexual transmission has accounted for almost two-thirds of all cases (1,011) followed by homosexual transmission (275), and bisexual contact (82). There have been only 24 perinatal, 13 blood<sup>3</sup> and six drug injecting cases reported. As of February 2002, 1,084 cases (66 percent) were asymptomatic and 549 (34 percent) were AIDS cases. Of the AIDS cases, 239 (44 percent) had died due to AIDS complications.<sup>4</sup>

However, these are reported cases; the estimated number of cases and deaths is much higher. The latest estimates are from the end of 1999. At that time, it was estimated that some 28,000 adults and children were living with HIV/AIDS and 1,200 died that year from AIDS-related causes.<sup>5</sup>

The Philippines is a low HIV-prevalence country. The rate of increase in HIV/AIDS is called “low and slow.” In February, for example, only three new AIDS cases were reported—two men and one woman. One death was reported between December and February.<sup>6</sup> Nevertheless, serological surveillance shows that the infection is already present in the main cities of the main islands of Luzon, Visayas, and Mindanao.

A number of reasons exist for the low prevalence level and its slow growth. These include: circumcision, which reduces transmission risk; geography (no land borders, many islands); the relatively low number of foreign tourists; the sexual conservatism of the people, the majority of whom are observant Catholics and Muslims; relatively low intravenous drug use (drugs are a problem, but intravenous use is low); the national, multisector AIDS policies; information, education, and communications (IEC) campaigns; and weak social/behavioral research, which may not be extensive enough to detect HIV/AIDS.<sup>7</sup>

In terms of gender and age, males are affected more than females (60:40 percent) in the Philippines. The predominant age groups are 30-39 for males and 20-29 for females. There are few cases of infected children (only 2 percent of the cases were children under 12 years of age).<sup>8</sup> Overseas foreign workers may seem to be the largest group infected, accounting for 28 percent of reported

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<sup>3</sup> The Philippine National Red Cross estimated that in 1999 about 500,000 bags of blood were received and tested. Of these, 54 were found to be positive when screened, but only one was confirmed as HIV seropositive. WHO and Do of Health (DOH). Consensus Report on STI, HIV and AIDS Epidemiology, Philippines 2000.

<sup>4</sup> Department of Health, National Epidemiology Center, HIV/AIDS Registry, February 2002.

<sup>5</sup> UNAIDS, Philippines Epidemiological Fact Sheets on HIV/AIDS and sexually transmitted infections, 2000 Update (revised).

<sup>6</sup> DOH, op. cit.

<sup>7</sup> UNDP: Current HIV/AIDS Status in Southeast Asia, With Special Emphasis on the Philippines. <http://www.undp.org.ph/dt/HIVaids/>

<sup>8</sup> Consensus Report, op. cit.

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cases (442), but that is probably because applicants for work abroad are tested more than other groups. No cases of HIV have been found yet among military recruits, which serve as a proxy of the general male population. This small number of HIV cases means that mother-to-child transmission (MTCT) is not likely to be a major factor in the medium term. The relatively secure blood transfusion service does not seem likely to be a significant channel for new infections.

In October 1998 the WHO Western Pacific Regional Office organized a regional workshop on STI services and education for FSW and their clients. A review of epidemiological data estimated the number of FSW in the region at proximately numbering >250,000. Roughly 100,000 are estimated to be working in the 10 current USAID focus areas. In the Philippines, brothel based FSW have approximately five clients per day but bar-based FSW only 3-5 clients per week.

There is no accurate data on the number of MSMs, although estimates are placed at 10% of the population (3.7 million MSM among 19-49 age group).

Although injecting drug use in the Philippines appears to be limited, the Philippine Health Department estimates there are 10,000 IDUs while other sources suggest the figure may be as high as 400,000 IDUs. Except for Cebu, in the southern part of the country, sentinel surveillance has stopped monitoring IDUs as none of the sites were able to come up with the requisite sample size of 100 per site. In October 2002 HIV prevalence among IDUs (Cebu only) was estimated at 1 % (1,776 cumulative total HIV cases: six cases were IDU).

The drug of choice in the Philippines is crystal metamphetamine, called “shabu”, which is usually smoked or inhaled. The use of this drug has grown substantially. In 1997 it was imported from China, Hongkong and Taiwan. It is now also being produced locally. The Philippines is a major producer and exporter of marijuana and which is also popular. Cebu City has an identified community of IDUs and the most popular drug for injecting in this area is the pharmaceutical analgesic Nubain. Needles and syringes can be bought from drugstores without prescription but needle and syringe sharing rates are high. A harm reduction program in Cebu has been making inroads against this since 1996 and there has been a steady decline in the sharing of injecting equipment. There may be a need to heighten and sustain activities.

The dominant at-risk populations are: registered commercial female sex workers (RFSWs), freelance female sex workers (FFSWs), men having sex with men (MSM), male sex workers (MSWs), injecting drug users (IDUs), and male clients of sexually transmitted infection (STI) clinics.<sup>9</sup> If a full-blown HIV epidemic were to start, it is likely to be in highly urbanized areas where the preponderance of unprotected sex and sharing of injecting equipment occur. The seroprevalence rate among female sex workers is greater than 1 percent in the cities of Quezon and Pasay in Metro-Manila, Angeles in Central Luzon, Iloilo in Panay Island, and General Santos in Mindanao.<sup>10</sup> However, it is estimated to be less than 1 percent in the cities of Cebu in the Visayas and Davao in Mindanao. Cases of HIV have been found among MSM and among IDUs, despite the much

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<sup>9</sup> DOH. Status and Trends of HIV/AIDS in the Philippines: The 2000 Technical Report of the National HIV/AIDS Sentinel Surveillance System, undated.

<sup>10</sup> 1 percent is the rule-of-thumb ceiling for low-risk classification.

smaller numbers tested from these groups. The principal risk behaviors are unprotected sex, low use of condoms, high STIs, poor STI health-seeking behavior, and lack of knowledge.<sup>11</sup> Although there is high awareness among these risk groups of what HIV is and how to prevent it, behavior lags far behind. Fewer than one-half (<35%) of Filipinos most at risk consistently use condoms. Consistent condom use rates remain low because of FSWs' non-use of condoms with regular partners. More than one-half of FSWs reported not using condoms when they had sex with non-regular partners although increasing trend in condom use during sex with non-regular partners, particularly among FLSWs have been observed (55%-67%). Among MSM, oral sex is more widely practiced than anal sex except in the cities of General Santos and Zamboanga. MSM tended to practice anal sex more with regular partners, particularly with non-paying regular partners. Condom use among MSM during last sex (anal) with non-regular partner (66%) was slightly higher than non-paying regular partner (58%). An unexpectedly high rate of injection drug use has been discovered to exist among deep-sea fishermen and FSWs in General Santos City. STIs remain high among both most at-risk and low-risk populations.<sup>12</sup>

The prevalence of high-risk behavior and high sexually transmitted infection (STI) rates indicates the potential for a devastating epidemic. USAID/Philippines acknowledges that early and effective targeting of HIV prevention interventions to high-risk groups remains critical because interventions diminish in cost-effectiveness as the infection moves out of the high-risk groups to other segments of the population.

. Behavior surveillance data indicate most of the sexual contacts in commercial sex occur without a condom, although condom use in the most affected cities appears to have risen significantly. Syphilis prevalence, a precursor of potential HIV prevalence, has been shown to average well above 5 percent among FFSWs (but not among RFSWs who are tested for STIs each week), MSM, and IDUs. Limited reach thus far of active surveillance and preventive education among MSM and IDUs raises the possibility of an undetected and continued rise in prevalence among these most at-risk groups.

## **B. Government Response**

The Philippine Government has responded aggressively to the HIV/AIDS threat and has adopted a dual strategy of surveillance and preventive education. The Department of Health (DOH) classified HIV/AIDS as a notifiable disease in 1986. The HIV/AIDS Registry was institutionalized the next year. This passive reporting system registered all Western Blot-confirmed blood samples submitted by HIV-screening in accredited hospitals, clinics, laboratories, and blood banks around the country. In 1993, USAID funded the AIDS Surveillance and Education Project (ASEP). With technical assistance from the World Health Organization (WHO), the DOH set up the National HIV/AIDS Sentinel Surveillance System (NHSSS). Today, there are 10 sentinel sites around the country that

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<sup>11</sup> USAID/Manila briefing; PowerPoint handout, April 16, 2002.

<sup>12</sup> Family Health International. The Philippines: Philippines Program Overview, 2000. <http://www.fhi.org/en/cntr/asia/Philippines/philippinesofc.html>.

conduct both serological and behavior surveillance each year.<sup>13</sup>

**Table 1: HIV/AIDS Sentinel Surveillance Sites**

<b>Luzon</b>	<b>Visayas</b>	<b>Mindanao</b>
• Quezon	• Cebu	• Davao
• Baguio*	• Iloilo	• Cagayan de Oro*
• Angeles		• General Santos
• Pasay		• Zamboanga

\*Non-AIDS Surveillance and Education Project sites

The Government established the Philippines National AIDS Council (PNAC) in 1992. It is located within the DOH and headed by a physician who is also Director of Family Health. PNAC is a coordinating body made up of 26 public and private organizations. One of its most

significant accomplishments was the enactment of The Philippine AIDS Prevention and Control Act of 1998 (RA 8504). HIV/AIDS education and services have been integrated into a broad variety of government departments (Education, Culture and Sports; Health; Interior and Local Government; Labor and Employment; Tourism; Social Welfare and Development; Foreign Affairs, National Economic Development; and the Department of Justice). Capacity development and funding have been provided at both the central and local government levels.

### **C. USAID Contributions 1992-2002**

USAID has been a strong supporter of the Philippine Government's HIV/AIDS efforts, especially in surveillance and preventive education. USAID's most significant contribution has been ASEP, which has been in operation for almost a decade. The fundamental objective of this support has been to prevent the rapid increase of HIV/AIDS through surveillance and preventive education.

In addition to the surveillance systems mentioned above, ASEP also includes an education intervention designed to promote HIV/AIDS prevention among the most at-risk groups, especially in the 10 project sites.

This educational intervention consists of individual and structural/environmental components. At the individual level, ASEP uses a community outreach and peer education approach (COPE) to educate vulnerable individuals about ways to prevent STI/HIV/AIDS. At the same time, it provides syndromic management of STIs. At the structural/environmental level, ASEP advocates policy changes at national and local levels to ensure that ASEP interventions are enabled and sustained.

### **D. Other Donor Contributions**

Assistance from other donors has been modest and appears to be declining such as:

- The Japanese International Cooperation Agency (JICA) and the Embassy of Japan plan to end current funding for HIV/AIDS activities and to focus on tuberculosis.
- The United Nations Children's Education Fund (UNICEF) plans to include HIV/AIDS

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<sup>13</sup> These are called HIV Serological Surveillance (HSS) and Behavioral Surveillance Survey (BSS).

messages in its five-province program to encourage healthy behavior among youth.

- The United Nations Fund for Population's (UNFPA) current country program, which runs to 2004, includes some support for HIV/AIDS prevention as part of its assistance to improve reproductive health services. This support includes organization of local AIDS council and BCC outreach for groups at risk in provincial cities and large towns in Cagayan, Nueva Vizcaya, and Quirino provinces in Region 2; and in Kalibo and Boracay in Aklan and Roxas City in Capiz in Region 6.
- The European Union (EU) has ended all funding for HIV/AIDS and no new activities are planned.
- UNAIDS manages \$100,000 in funding for eight selected nongovernmental organizations (NGOs), averaging \$12,500 per NGO.<sup>14</sup>
- An international NGO (PLAN International) includes some HIV/AIDS prevention activities in its community-based poverty alleviation projects in Samar and Leyte, two provinces known to be among the sources of female migrants to cities many of whom become commercial sex workers.
- The Women's Health and Safe Motherhood Project jointly financed by World Bank, Asian Development Bank, and AusAID, which ends in 2003, includes support to diagnosis and treatment of reproductive tract infections, including STIs.

#### **E. ASEP Achievements and Future Needs**

The ASEP evaluation conducted in 2001<sup>15</sup> showed that both the surveillance and education/policy components of the project have been successful. It also showed that there are gaps that need to be filled.

**Surveillance.** Both the HIV Sentinel Surveillance (HSS) and the Behavioral Surveillance Survey (BSS) have produced useful information. The HSS has been institutionalized within DOH in the National Epidemiology Center (NEC), which is responsible for analyzing national HIV/AIDS trends. Surveillance has shown that prevalence continues to remain at very low levels (< 1 percent). Both the national government and the local government units (LGUs) recognize the value of the HSS and will continue to support its implementation. The BSS has also produced important information, but the methodology needs strengthening and LGUs, in particular, need to be convinced that it deserves their support. A major shortcoming in the surveillance systems has been the difficulty in identifying enough MSM and IDUs to conform to the surveillance sample requirements (300 cases per group per site for HSS; 120 per group per site for BSS). This information is vital, as any rapid acceleration in HIV/AIDS is likely to occur first in these groups. Further support is needed to identify adequate MSM and IDU cases in the 10 surveillance sites and to continue support for the BSS until they can be taken over and funded by the LGUs. This should be a priority area for USAID support.

**Education and Policy.** This component consists of BCC risk-reduction activities targeted at most

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<sup>14</sup> James Chin, et. al. Final Evaluation of the AIDS Surveillance and Education Project (ASEP), USAID/Manila, May 14, 2001, p. 41.

<sup>15</sup> Chin, op. cit.

at-risk groups (MARGs) and policy work with city governments to provide local support for key elements of surveillance and prevention. Again, both have been done well and have demonstrated that local NGOs can develop effective education programs that reach all at-risk groups (RFSWs, FFSWs, MSM, IDUs, MSWs and male clients<sup>16</sup>). Some LGUs will take over these programs, but others still need to be convinced of their value. The principal shortcoming of the education and policy components, as has been with surveillance, is reaching the MSM and IDU target groups. More effort is needed in identifying and building the capacity of local NGOs to identify and educate these groups. USAID support in this area is clearly needed.

**Expansion.** Expansion of these components to other cities has been proposed by a number of organizations. PNAC has identified additional 24 high-risk zones that it believes should replicate the ASEP model (see Appendix B). The DOH, in collaboration with the USAID-supported POLICY project, is currently working with eight LGUs that are interested in replicating ASEP. These and other LGUs appear to be willing to support the setting up of both components in their jurisdictions and NEC is willing to provide technical assistance to set up the surveillance systems. There is not a pressing need for USAID to support this expansion. NEC has stated, for example, that it does not need additional sites for its principal objective, which is to generate national-level estimates.

**Extension.** Another suggestion is to extend the coverage of the 10 current sites to sections of their contiguous cities and towns where MARGs can be reached. This would expand each site's catchment area. It should produce greater coverage, which would also result in better detection of cases for the two most at-risk groups that are difficult to access. This extension would need to be partially supported by USAID in some sites, but would eventually have to be taken over by the LGUs. This would be a priority investment for USAID.

**Sustainability.** Sustainability is a central issue. USAID does not want to start activities that cannot be turned over to the national government or LGUs for future support. So far, both the national government and some LGUs have been willing to take over the funding of HIV/AIDS prevention activities. Others would need to be convinced, which requires grass roots advocacy from local NGOs and LGU "champions." It is easier to sell the LGUs on supporting the HSS for registered sex workers. It is much more difficult to get them to see the value of the BSS, preventive education, treatment services, and, in particular, reaching the other three most at-risk target groups (FFSWs, MSM, and IDUs). This is a critical policy/advocacy issue that USAID should support.

**Other Target Groups.** The ASEP evaluation and a number of stakeholders suggested that the new project should target minors (children under 18 years of age) and should include prostitution as a problem that needs to be addressed. Although these are important areas that clearly deserve attention, they fall outside the mandate of the HIV/AIDS program, which is to prevent the spread of these infections. As noted in the epidemiological data, the incidence of HIV/AIDS among children in the Philippines is extremely low and does not warrant special attention. Likewise, campaigns to

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<sup>16</sup> MSWs are required, like RFSWs, to make weekly visits to the Social Hygiene Units for testing. However, because there are so few of them, they are not included in the HSS or BSS. Male clients are not included in the surveillance, either, since they represent the general population and not a "most at-risk group." They are targeted for preventive education, however.

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eliminate prostitution, especially child prostitution or to find alternative lines of work for sex workers, are laudable endeavors but are better addressed through woman and child protection programs. The Philippine Reproductive Health program includes a component to eliminate violence against women and children and has mandated the establishment of mother and child protective units in all provincial hospitals. Thus, reproductive health would be an appropriate vehicle for addressing these issues. USAID should not invest its limited HIV/AIDS funding in these areas.

Several stakeholders also suggested special attention for overseas foreign workers, truck drivers, deep-sea fishermen, merchant mariners, and other at-risk populations. These are not high at-risk categories in themselves. The most-at-risk groups are MSM and IDUs who happen to be overseas foreign workers, truck drivers, or the like. There is sufficient evidence that there are IDUs among deep-sea fishermen and these would need to be targeted through surveillance sites that include ports where deep-sea fishermen can be found. USAID should support one-time studies of such occupations as truck drivers to determine if there are significant numbers of most at-risk groups or high-risk behaviors within those groups. If these studies determine that there are, then these occupations could be added to the HSS and BSS.

**Priority Needs.** From this review, the priority HIV/AIDS needs over the next four years are to fill the most critical gaps in surveillance, education, policy, and advocacy, especially with, respect to the underserved, most at-risk FFSW, MSM, and IDU populations in the 10 ASEP sites.

## II. PROPOSED USAID FOUR-YEAR STRATEGIC PLAN

### **A. Strategic Objective for HIV/AIDS: Improved Health Sustainably Achieved**

The Mission's Strategic Objective (SO) for Population, Health and Nutrition (PHN) incorporates a broad range of health concerns, including HIV/AIDS. The Design Team has developed a Strategic Plan that places HIV/AIDS support within that SO (see shaded boxes in the PHN Results Framework on the next page). The proposed strategy attempts to respond to the priority needs while remaining within a budget that is roughly equivalent to the current budget. It proposes cost-effective interventions designed to be sustained by the local government units (LGUs) prior to the end of project funding. The principal objectives for HIV/AIDS would be as follows:

#### ***1. Keep HIV/AIDS Infections Low and Slow***

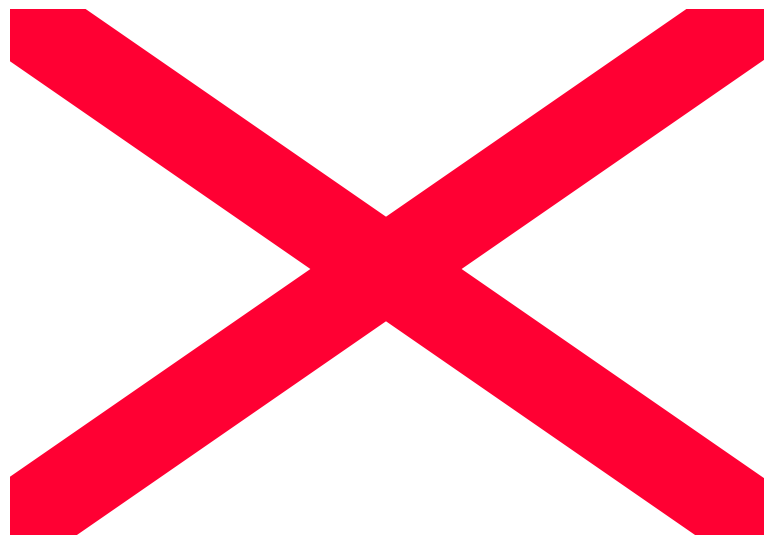
The major objective of this strategy is to avoid any increase in HIV/AIDS infections. The Philippines is in the enviable position of having a low level of prevalence and a slow increase. It is extremely difficult to reduce current prevalence, but it is possible to avoid increases, and that is the primary objective—to avoid moving to a concentrated epidemic.

#### ***2. Prevent Infections Among the Most at-risk Groups***

The key to maintaining this low and slow pattern is to prevent HIV increases among the most at-risk groups (MARGs) because once they become infected the disease can spread rapidly. This is especially true among men who have sex with men (MSM) and injecting drug users (IDUs), and that is why it will be so important to monitor infections in these two MARGs.

#### ***3. Integrate Sustainable HIV/AIDS Interventions into LGU and NGO Programs***

It is critical that these USAID-funded interventions are continued after project funding ends in 2006. Otherwise, the investments made in surveillance, education, and policy development would be wasted and the primary objective of keeping HIV/AIDS infections low and slow would be compromised. Thus, each intervention proposed must be affordable and cost effective. USAID funds should be viewed as “seed” money that helps LGUs and nongovernmental organizations (NGOs) develop and test interventions they could replicate and continue to support after USAID funding comes to an end.





## **B. The Strategy**

The proposed strategy actually cuts across two of the four IRs of the PHN SO. Three of the proposed interventions correspond with IR1: LGU provision and management of HIV/AIDS services strengthened. One corresponds with IR4: Policy environment and financing for provision of services improved. These four interventions make up the strategy for the new project.

In general, the strategy is to: 1) improve health by strengthening HIV/AIDS surveillance; 2) develop plans for sustaining LGU support; 3) strengthen NGOs to identify and educate the most at-risk groups; and 4) create a positive policy environment to remove obstacles to implementation and continuation.

Three of the components strengthen government capacities to monitor and prevent infection. Together they account for 50 percent of the resources budgeted. The remaining component is NGO capacity development, which accounts for 45 percent of the resources. A large number of NGOs (about 20 ) will have to be identified and contracted. Each of the four components of the strategy has been integrated into a PHN IR and sub-IR. The wording of the IRs and sub-IRs has not been altered. They remain exactly as stated in the PHN Results Framework. The objectives and activities that are listed under each sub-IR constitute the operational strategy. HIV/AIDS indicators for the SO, IR, and sub-IRs have also been proposed. They can be found in Section III: Performance Indicators.

## **C. IR.1.1: Key Management Systems to Sustain Delivery Improved**

Although the current surveillance system is operating relatively well, the methodology needs to be strengthened, additional data need to be collected, and the HIV Sentinel Surveillance (HSS) and Behavior Surveillance Survey (BSS) must be expanded to provide adequate and accurate information on the MARGs, especially MSM, and IDUs.

### **1. Objective**

Improve HIV/AIDS surveillance, especially among the most at-risk populations. Activities should include:

- Extending surveillance and education to selected areas contiguous to AIDS Surveillance and Education Project (ASEP) sites;
- Expanding HSS of female freelance sex workers (FFSWs), MSM, and IDUs in current sites and contiguous areas;
- Strengthening NGO capacity to reach MARGs;
- Conducting one-time studies of other possible at-risk groups;
- Integrating HSS with ID surveillance within the National Epidemiology Center (NEC) and LGU;
- Strengthening BSS methodology; and
- Continuing BSS support until transition to LGU.

## **2. Rationale**

Second-generation HIV surveillance is an important tool for managing the battle against HIV/AIDS, and it is critical to have it in place in the Philippines. The use of second-generation HIV surveillance in the Philippines can help both national and LGU institutions monitor the epidemic and guide their responses to it through the collection, analysis, and use of data essential to AIDS control programs.

Second-generation surveillance relies on data collected from biological surveillance (HSS), behavioral surveillance (BSS) and other sources (HIV/AIDS case registry), STI surveillance, and TB surveillance, to describe the country's HIV epidemic and respond effectively. It aims to improve data collection from these sources, support improved methods for building estimates and modeling the epidemic, and encourage better ways of using the data for advocacy, planning, monitoring, and evaluation.

## **3. Activities**

**a. Extending surveillance and education to selected areas contiguous to ASEP sites.** The NEC has made it clear that expansion of HSS into additional LGUs is not necessary for national surveillance purposes. Thus, HSS and BSS would be continued in the current eight ASEP sites and the two former ASEP sites. There is some concern that Pasay and Quezon City may not be willing to support the continuation of surveillance. If that turns out to be the case, two other sites in Metro Manila should replace these two sites. Thus, the total number of sites would remain at 10.

The DOH would like to expand surveillance to additional 24 sites; however, this would be extremely expensive. Neither the DOH nor USAID has funds to do this. NEC has made a commitment to provide technical assistance to LGUs that want to set up their own surveillance systems. As mentioned previously, the DOH and the POLICY Project are attempting to replicate the ASEP model in eight of these 24 sites. USAID would not fund this type of expansion. However, USAID would only support technical assistance to NGOs and LGUs interested in reaching MSM, IDUs, and FFSWs in areas contiguous to the existing ASEP sites. This would allow the present sites to extend their coverage (both surveillance and preventive education) to sections of nearby towns or cities that include at-risk groups. This would extend their current catchment areas and enable the 10 sites to identify and reach more at-risk subjects (especially MSM and IDUs, but also registered female sex workers (RFSWs) and FFSWs) for potential expansion in future years. (See Appendix B: Table 5 for list of current ASEP and potential extension and future expansion sites)

**b. Expanding HSS of FFSWs, MSM and IDUs in the current sites and contiguous areas**

The ASEP-funded LGUs have, for the most part, committed to funding ongoing HSS in their jurisdictions. LGU DOH/Social Hygiene Clinic (SHC) staffs engaged in the conduct of the HSS has gained valuable experience in conducting surveillance, particularly among RFSWs. Unfortunately, it was only among the RFSWs that the sites were able to consistently attain the desired sample sizes. Had the desired sample sizes for other groups (MSM, IDUs, and FFSWs) been attained at all sites, the HSS would have been more sensitive in its ability to detect HIV-positive subjects.

Since LGU/social hygiene staff would continue to undertake the HSS activities, USAID would only need to provide support for update training of the LGU DOH/Social Hygiene Clinic staff in advances in HSS methodology and best practices. This would include training related to working with the MARGs, particularly MSM and IDU groups. These efforts are needed to gather more comprehensive data for the HSS on the other three most at-risk populations (FFSWs, MSM, IDUs).

**c. Strengthening NGO capacity to identify most at-risk groups.** Experience has shown that a strong community-based NGO presence is essential to gain access to such difficult to reach populations as MSM, FFSWs, and IDUs. USAID should strengthen NGO capacity to identify and access these populations, not only for surveillance purposes, but also to target current and future prevention activities for these groups, since any acceleration in HIV prevalence would occur in these groups first.

NGOs and LGUs need to determine whether there are sufficient numbers of identifiable MSM, IDUs, and FFSWs in their areas to conduct adequate surveillance of these groups. If not, there would be no point in conducting surveillance. Therefore, as a component of the LGU surveillance strengthening, USAID should support:

- Rapid demographic assessments to determine the number of the MSM, IDUs, and FFSWs in any of the 10 HSS sites and extension areas that do not have accurate estimates of the number of each MARG (these assessments would be carried out by LGU surveillance staff in collaboration with local NGOs and/or local universities);
- Training to enable NGO staff to understand the rationale and methods for undertaking surveillance; and
- TA to explore the use of surveillance data for a variety of issues ranging from advocacy to behavior change interventions.

**d. Conducting one-time studies of other at-risk groups.** There has also been a great deal of interest in expanding surveillance to such groups as overseas foreign workers, deep sea fishermen, merchant mariners, truckers, and other possible at-risk groups. USAID would support a limited number of one-time behavioral and seroprevalence studies of such groups to determine the prevalence of HIV/AIDS infection among them and to describe their risk behaviors. This information could be useful in itself for future HIV/AIDS prevention strategies. If studies show that significant numbers of individuals in these groups are engaged in high-risk behaviors, the LGUs and NGOs may want to include these groups in their future HSS and BSS.

**e. Integrating HSS with infectious disease (ID) surveillance within the NEC and LGU.**

During the previous strategy period, HSS was supported by ASEP and implemented by the DOH, with assistance from World Health Organization/Western Pacific Regional Office (WHO/WPRO) and LGU partners. As part of the institutionalization strategy of the government, the NEC of the DOH intends to assume the national coordination of the HSS and to integrate HIV/AIDS surveillance with an infectious diseases surveillance system, which would also cover dengue, malaria, and tuberculosis. Well-staffed regional epidemiological surveillance units at each Center for Health Development in the regions would be part of this system. LGUs will still have to be convinced to adopt this integrated surveillance model and the NEC still has to address its own staffing and administrative constraints due to the re-engineering of the DOH. USAID could support the NEC in managing the transition of the HSS into the integrated surveillance system by providing technical assistance in planning, implementing, monitoring, and evaluating the integration effort at the NEC and at the LGU levels.

**f. Strengthening the BSS methodology.** The BSS was established in the 10 HSS sites as part of the second-generation surveillance system and to complement the HSS. BSS is a critical tool for monitoring behavior change among the most at-risk populations.

The content and methodology of the BSS should be such that useful and accurate data are collected. The current BSS has raised some concerns in this area. For instance, survey questions are not specific enough in addressing specific sexual risk behaviors. They do not distinguish between oral sex and receptive anal intercourse, nor does the survey distinguish between regular paying clients and regular nonpaying sex partners, such as husbands and boyfriends. This is important information that is needed to determine what types of preventive messages are needed. For example, in the BSS high rates of condom use by RFSWs with nonregular partners do not correlate with data from field studies of reported rates of condom use by the male clients.

USAID should support the following activities to remedy these deficiencies:

- Further refinement of BSS questions so that the survey is in line with current global best practices;
- Validation studies of particular survey responses, such as high condom use rates among RFSWs;
- Secondary analysis of the data, which can be used by stakeholders; and
- Training for NGO and DOH staffs in best practices for conducting BSS

**g. Continuing BSS support until the transition to LGUs** Research Institutions (RI) were funded in the ASEP sites to carry out the BSS, while the City Health Office (CHO) in the two non-ASEP sites conducted the BSS on their own. The LGU officials in the ASEP sites have not chosen to continue support for the BSS. Despite possible negative incentives, USAID should continue to fund BSS in the ASEP sites with the proviso that transition plans agreed upon by the Philippines National AIDS Council (PNAC), DOH, the RI and the LGUs are developed and implemented prior to the end of project funding. These transition plans would help insure the formal commitment of the LGUs to continuing the BSS before the end of the USAID strategy. The plans would address LGU, RI, and NGO roles and capacity development needs. If it appears that the LGUs would not be willing or able to make this commitment, USAID may decide to switch its support to the DOH to insure

that BSS data are collected together with the HSS.

#### **D. IR 1.2 LGU Financing of Key Health Programs Improved**

Once the surveillance and education systems have been established, it will be essential for the LGUs to prepare to take them over. This should be done early in the strategy implementation to make sure that sustainability objectives are incorporated into each LGU and NGO plan from the beginning.

##### **1. Objective**

Facilitate planning for LGUs to sustain HIV/AIDS preventive education and health services for the most at-risk populations. Activities should include:

- Developing a strategy to sustain prevention activities;
- Developing plans for LGUs to absorb prevention activities; and
- Piloting LGU contracts with NGOs in prevention activities.

##### **2. Rationale**

The ASEP evaluation correctly defined the sustainability issue in terms of what it takes to keep the HIV/AIDS epidemic at its low/slow level. Planning for sustainability must determine which activities are essential and must be continued and what new activities and capabilities must be developed to sustain the low/slow pace. Such planning would engage local stakeholders (especially officials from barangays in "red light districts," city government officials, and local NGOs) in sustainability planning.

Cities where the ASEP was implemented have already demonstrated the benefits of preventive education and health services for RFSWs and FFSWs. In most of these cities, arrangements have been made to sustain the surveillance, education, and health services to RFSWs. They are based in entertainment establishments and are required to come to the Social Hygiene Centers (SHC) for weekly swab tests. Thus, they are relatively easy to identify. However, the sustainability of surveillance coverage and outreach services for FFSWs is still in doubt. They are not required to come to the SHCs and are, therefore, much more difficult to identify. The most difficult to identify and reach are MSM and IDUs. Many LGUs do not yet understand why these groups need to be sought out. The value of this has not yet been sufficiently demonstrated, partly because ASEP reduced its efforts among these vulnerable groups at the latter half of the project. Thus sustaining this portion of the local prevention effort is likely to be even more difficult unless some serious lobbying is done at the outset.

**3. Illustrative Activities:**

**a. Developing a strategy to sustain prevention activities.** USAID should provide support to enable LGUs to develop local plans and strategies for serving three underserved MARGs. These are FFSWs, MSM, and IDUs. Such support should include, for example, the development of a generic strategy for sustained serological and behavior surveillance combined with appropriate health services and BCC to the groups most-at-risk. Such a strategic framework would include procedures to estimate the costs and benefits to the whole locality of efforts to prevent HIV infection among these groups. At this point, project staff and NGO partners would identify local “champions” in the LGU power structure to sponsor supporting resolutions and budget line items to ensure continued political and financial support for the interventions. By showing how the benefits of HIV prevention accrue to everyone, the new project would then be able to build a justification for public financing of these services. Opportunities would be identified for integrating family planning/reproductive (FP/RH) into the education and service package for these groups. This would have the dual benefit of increasing both the demand for and the supply of more comprehensive services for MARGs. Finally this strategy would include exploring various options for local financing.

**b. Developing plans for LGUs to absorb prevention activities.** Once a sustainability strategy is understood and accepted by key stakeholders in the locality and championed by an LGU official, USAID should then support activities to transform this generic strategy into locality-specific sustainability plans in each of the 10 sites. Such a plan will feature a time-bound set of actions that would ease the absorption by the LGU of the costs to sustain HIV/AIDS prevention, including any appropriate enhancements, such as the addition of FP and RH services. For example, a local plan might lay out several stages, with the first being an agreement that the LGU would take over responsibility (with possible cost sharing with entertainment establishments) for the preventive and FP/RH activities for FFSWs. Specific arrangements for sustaining prevention among FFSW, MSM, and IDU groups would be phased in at later stages. Each local sustainability plan would need to be negotiated and advocated within the locality. The process leading to the adoption of the plan could be used as an opportunity for building a broader political constituency and broad-based ownership of HIV/AIDS prevention. The work of ASEP in supporting the organization of local AIDS councils, adoption of local AIDS ordinances, among others, would be the ideal foundations for such a planning-cum-advocacy process.

**c. Piloting LGU contracts with NGOs in prevention activities.** One key barrier to local sustainability is the relatively undeveloped LGU administrative experience in procuring contracts for services from NGOs or in making public-purpose grants available to NGOs. The lack of models in administrative practice has prevented LGUs from promptly replacing external donor funding for NGOs with LGU funding, despite an apparent willingness and capacity to do so. The ASEP evaluation recommended further assistance to remedy this situation. Under the proposed strategy, USAID would provide support through technical assistance to and training for LGU procurement officials to develop and pilot-test procurement procedures. Another strategy could be to provide a limited “matching of funds” to the LGU initially.

**E. IR 1.3: Performance Among Service Providers Improved**

Local NGOs will need to improve MARG outreach and casefinding for surveillance, as well as preventive education and advocacy. They will require a good deal of capacity development to meet project objectives.

**1. Objective**

Strengthen NGO capacity to identify and reduce the threat of HIV/AIDS among the MARGs. Activities should include:

- Identifying NGOs capable of reaching the most-at-risk groups not adequately being reached at this point (FFSWs, MSM, and IDUs), and help them build their institutional capacity;
- Providing support for NGO operations and implementation;
- Developing the capacity of the NGOs to identify and recruit MARGs for voluntary counseling and testing;
- Developing the capacity of the NGOs to develop and disseminate BCC messages and materials to reduce unprotected sex and harmful practices;
- Identifying and support testing of innovative models for improving BCC for the most-at-risk populations;
- Linking NGO work among the most-at-risk groups to condom social marketing activities;
- Building NGO capacity to provide information, education, and communications (IEC) in STI/FP/RH to at-risk groups, including referral to LGU and barangay health units;
- Strengthening NGO capacity to advocate for policy change and funding; and
- Supporting NGOs and NGO government partner participation in regional/global conferences and HIV-focused events.

**2. Rationale**

The goal of IEC and BCC activities for the most at-risk groups is to bring about behavior change. To reach and sustain activities for the long term, community-based organizations (CBOs) that could work with these MARGs must be identified and strengthened. This must include the strengthening of management capacity, as well as their ability to reach target populations with technically sound prevention activities.

Furthermore, effective country-level HIV/AIDS responses can only be achieved through the concerted efforts of both governmental and NGOs. USAID-supported HIV efforts in the Philippines under previous strategies did not fully develop NGO capacity. NGOs in the Philippines have a proven record of collaboration with the government in HIV/AIDS. They are willing to expand that collaboration, but they also want to improve their capacity to serve their target groups and to manage their affairs professionally. USAID, through its experience working with civil society and HIV programming in countries around the world, is especially well positioned to support such NGO capacity building and to share lessons learned from other HIV/AIDS programs.

USAID is committed to working with NGO partners to build their capacity. The goal is to improve NGO capacity to deliver HIV prevention programs to the most at-risk groups. This will be achieved through technical assistance and training to strengthen management, services, community relations, and NGO network.

### 3. Activities

**a. Identify NGOs capable of reaching the most at-risk groups (FFSWs, MSM, and IDUs), and help them build their institutional capacity.** USAID should provide support to NGOs through LGUs or directly to reach the most at-risk groups. It is difficult to estimate how many NGOs would need to be recruited. That would depend on both supply and demand conditions. Table 2 indicates there are quite a few qualified NGOs in most sites. For example, Cebu seems to have enough experienced NGOs to work with all four MARGs, as do three other sites. Iloilo and Cagayan de Oro, on the other hand, only appear to have one NGO that can work with male clients. They do not seem to have any NGOs that could work with the other MARGs.

USAID should support an assessment of available and appropriate NGOs in each site to answer the supply question. Which local NGOs are capable of (or could become capable of) working with each MARG? If there are not enough qualified NGOs in a given site, can NGOs from other sites take on the responsibility? Could an NGO

that works with MSM in one site set up a branch in another site? Staff would also answer the demand question: how many of each kind of MARG are there in each site? Are there enough to warrant more than one NGO? Are there too many of one MARG for a single NGO to handle? Is there enough information to make that decision or does a rapid assessment needs to be undertaken?

USAID recognizes that one of the best ways to reach these groups is through peer outreach. Therefore, in addition to building the capacity of NGOs and their Community Health Outreach Workers (CHOWs), USAID is committed to fostering the development of the technical abilities of individuals from the target populations of FFSWs, MSM, and IDUs to become peer educators. In addition, USAID should support capacity building in people living with HIV/AIDS (PLWHA) organizations to work with the NGOs as advocates or educators. In sites where such an organization does not exist and there is a need, networks of PLWHA could be associated with an existing USAID-supported NGO.

**Table 2: Potential NGOs in Project Sites**

Sites	MSM	IDU	RFSW, FFSW, MSW	Male Clients	Total
Baguio	v			v	2
Angeles	v		v	v	3
Pasay	v	v	v	v	4
Quezon	v	v	v	v	4
Cebu	v	v	v	v	4
Davao	v		v	v	3
Zamboanga	v		v	v	3
Gen. Santos	v	v	v	v	4
Iloilo				v	1
CDO				v	1
Total	8	4	7	10	29

Source: Stakeholder Workshop, Manila 4/30/02

Once identified, USAID should support capacity building of NGOs in organizational development and management. Examples of skills to be developed are: human resource management, financial management and reporting, strategy and work plan development, monitoring and evaluation, fundraising, proposal writing, and resource planning, as well as capacity building in HIV technical areas.

**b. Provide support for NGO operations and implementation.** USAID may need to support the project personnel and operating costs for the NGOs. There would be approximately 20 NGOs in the 10 sites, an average of two per site. There would be at least one NGO in each site to reach one or more of the MARGs. There may not be enough IDUs to warrant outreach in some sites. On the other hand, all sites would probably have enough MSM and FFSWs to warrant developing NGOs to work with each of these groups. Those NGOs that work with RFSWs may also be able to work with FFSWs. As noted above, the project implementer would conduct an assessment at the start of the project to determine the number and types of NGOs, CHOWs, and peer educators needed.

To make sustainability a reality, agreements would be reached with the LGUs at the outset that USAID financial support would begin to phase out in Year 3 of the project and would be completely phased out at least six months before the project ends.

**c. Develop the capacity of the NGOs to identify and recruit MARGs for voluntary counseling and testing.** USAID should provide support for capacity building in identifying and recruiting most-at-risk individuals for voluntary counseling and testing (VCT). Innovative models used in other countries should be highlighted, including those that build community empowerment as a way to reduce stigma and build trust among MARGs. Since HIV VCT is also an important entry point for both prevention and care services, USAID support should include capacity building in proper and effective HIV/AIDS counseling and referral to testing services. Where it might be more cost-effective, USAID should also build the capacity of NGOs to do the full range of VCT services. Currently, there are only a few NGOs that are implementing VCT program in the Philippines. ReachOut Foundation NGO clinic and the FriendlyCare Foundation are providing HIV testing and counseling. Other NGOs are only able to provide counseling and refer their clients to other testing centers with DOH- accredited laboratories, including the Research Institute for Tropical Medicine (RITM), 8 Social Hygiene Clinics (located in cities implementing AIDS Surveillance project), or to 42 other private (employment) laboratories. Private laboratories that provide for HIV screening for overseas employment perform the bulk of HIV testing in the country but do not providing for counseling.

**d. Develop the capacity of the NGOs to develop and disseminate BCC messages and materials to reduce unprotected sex and harmful practices.** CHOWs and peer educators will also receive extensive training in behavioral change communication strategies, messages and materials designed to reduce unprotected sex and harmful practices. The global lessons learned in HIV/AIDS BCC demonstrate that individuals will often hear and internalize messages more readily when the messages are about specific behaviors in which they engage (such as oral and anal sex, as opposed to generic safer sex messages). Project trainers and consultants would be drawn from a broad range

of experiences to help trainees learn how to develop and disseminate information effectively.

**e. Identify and support testing of innovative models for improving BCC for the most at-risk populations.** Different target groups need different BCC. Also, the membership of these groups is fluid as new members join and others drop out. Thus, USAID should also provide a limited amount of funding to enable NGOs to develop and test innovative ways to approach especially hard-to-reach individuals.

**f. Link NGO work among the most at-risk populations to condom social marketing activities.** USAID would provide support to NGOs in understanding and facilitating contraceptive social marketing (CSM) to target audiences. Consistent use of condoms is a critical behavior by which the most at-risk individuals for sexual transmission of HIV, as well as the clients of sex workers, can protect themselves from HIV. The good news is that condoms are very affordably priced and abundant in the Philippines. The bad news is that condoms carry a negative stigma, are underutilized by at-risk groups and not always conveniently available in the places and during the times that individuals are most likely to engage in high-risk acts.

USAID provides condoms to the DOH, which distributes them at no cost to the general public. These condoms are available in many DOH outlets, but are not in great demand by MARGs. USAID currently does not sponsor CSM in the Philippines. But KfW, the German development assistance agency, does, through DKT International. This is the only CSM program in the Philippines. It includes support for subsidized condoms, media campaigns, and IEC materials, most of which are directed at the general population with some focus on youth and young adults. DKT had worked with ASEP in the beginning of the project and had some success in collaborating with local NGOs to reach MARGs. DKT's involvement ended about halfway through the project. However, it is still interested in being involved in CSM aimed at MARGs. DKT also has received a \$150,000 grant from the Department for International Development (DfID) to pilot social marketing of lubricants and to target the most at-risk groups for HIV. Thus, there is an opportunity for USAID to leverage this support with a modest amount of funding to DKT to target MARGs in the 10 project sites. The principal gap in the MARG areas is not the lack of condoms, but their convenient distribution. DKT could be brought into the project to work with NGOs, their CHOWs, and peer educators to identify outlets convenient to MARGs, stock them with affordable condoms, and to market them to the MARGs.

**g. Build NGO capacity to provide IEC in STI/FP/RH to at-risk groups, including referral to LGU and barangay health units.** USAID should provide training in IEC, counseling, and referral to other relevant health services, especially STI, FP, and RH. As part of this training, NGOs will learn how to sensitize health providers about the needs of the most at-risk groups as a way to reduce stigma and encourage utilization of STI, FP, and RH services.

**h. Strengthen NGO capacity to advocate for policy change and funding.** USAID should support training of NGOs in policy advocacy, which will enable them to engage in policy reform that affects their clients and help them lobby for adequate funding for HIV prevention. USAID-supported HIV strategies have had great successes at leveraging pro bono media coverage and public service announcements for HIV awareness. These messages, which are often directed at the general public, can help reduce stigma surrounding HIV and increase public support for outreach for

behavior change among the most at-risk groups. Therefore, USAID should encourage the project implementers and their partner NGOs to seek pro bono media coverage for their activities.

**i. Support NGOs and NGO government partner participation in regional/global conferences.** USAID should support participation in conferences, training and similar fora to help its partners keep up to date on current trends, innovations, policies, lessons learned, and opportunities for further capacity development.

## **F. IR 4.2 Appropriate Legal and Regulatory Policies to Promote Provision of Services Established**

Progress has been made by PNAC to mobilize support for HIV/AIDS prevention, but significant obstacles need to be overcome. Convincing LGUs to accept the ASEP package is one, ensuring adequate supplies and distribution of condoms is another.

### **1. Objective**

Assist PNAC, using the mandate of RA 8504, to further strengthen implementation and local interpretation of national policies supportive of financing and delivery of HIV/AIDS prevention at local levels. Activities should include:

- Assisting PNAC in mobilizing its partner agencies to plan and conduct an advocacy campaign for adoption of the ASEP package by LGUs;
- Assisting PNAC in mobilizing its partner agencies to develop a national plan for condom supply security;
- Assisting PNAC in mobilizing its partner agencies to develop a strategy on STI diagnosis and treatment;
- Assisting PNAC in mobilizing its partner agencies to develop a national policy for VCT for HIV/AIDS; and
- Assisting PNAC to develop a Department of Interior and Local Government/Philippine National Police (DILG/PNP) directive on harm reduction.

### **2. Rationale**

ASEP provided support to NGOs and LGUs in reaching some of the most at-risk groups with surveillance, health, and preventive education services. ASEP began when the legal and policy framework for the national response to HIV/AIDS was at a rudimentary stage. By the time ASEP ends in 2002, however, the landmark legislation—Republic Act 8504, the Philippine AIDS Prevention and Control Act of 1998—will be nearly five years old. The challenge now is to transform the strong and clear mandates of the law into enabling conditions for a more vigorous and sustained response to HIV/AIDS at the local level.

LGUs, despite their best intentions, cannot be fully self-sufficient in their local response to HIV/AIDS. Many of them do not have ready access to knowledge and information about the most effective ways to prevent HIV/AIDS. For example, the best practices and relevant experience of the eight cities covered by ASEP may not be fully known to localities that could benefit from such

knowledge. LGUs providing health services and regulating other health providers in their localities also depend on technical guidelines and service protocols provided by the national government. Such important HIV/AIDS prevention practices as condom use and prompt and proper STI treatment depends not only on the awareness and motivation of clients but also on the availability, cost and quality of condoms, and STI drugs. Many persons who are most at-risk for HIV infection live and work in areas subject to periodic raids by police and other authorities. If disease surveillance, health care, and preventive education were to reach these persons, certain policies concerning police operations would need to be adopted to facilitate the work of NGOs and LGUs. PNAC would be best suited to take the initiative in these matters, since it has both the legal mandate and access to the necessary resources to act expeditiously. Working through PNAC would be the most viable channel for pursuing the broad recommendation from the ASEP evaluation that calls for USAID to address policy, environmental, and structural constraints affecting HIV/AIDS prevention among the most at-risk groups.

### **3. Activities**

**a. Assist PNAC in mobilizing its partner agencies to plan and conduct an advocacy campaign for adoption of the ASEP package by LGUs.** USAID should assist PNAC to mobilize partner agencies in utilizing the ample data, practices, and experience from the eight ASEP sites to plan and launch an advocacy campaign for LGUs. Such a campaign will help LGUs with large at-risk populations to adopt and sustain the package of HIV/AIDS prevention activities demonstrated by ASEP, as well as FP and RH. This package consists of behavioral surveillance, STI diagnosis and treatment, condom use promotion, preventive education, and behavior change communications. The targets are RFSW, FFSW, MSM, and IDU populations in and around the LGUs' jurisdiction. Consideration would also be given to assisting LGUs in revising their zoning regulations to enable health and education services to reach greater proportions of at risk populations that are involved in commercial sex. The campaign would be based on a sustainability strategy (mentioned above in IR 1.2). For best results, the advocacy campaign would select its target LGUs from among those with MSM and IDU risk groups, not only RFSWs.

**b. Assist PNAC in mobilizing its partner agencies to develop a national plan for condom supply security.** USAID should assist PNAC in working with its partner agencies in developing better operational policies on the three critical HIV/AIDS interventions, namely: condom use, STI case management, and HIV/AIDS VCT. Condom supplies are adequate in the 10 project sites. The most significant problem is the shortage of convenient distribution points. A related issue is the need for continual marketing at these distribution points. Otherwise demand slows and eventually ends. At the national level, condom supplies are a major concern. All three of these issues—convenient local distribution points, marketing linked with distribution, security of national condom supply—need to be addressed. USAID should support technical assistance, training, promotional, planning, and pilot testing in selected LGU sites, preferably in collaboration with social marketing partners. There is an opportunity to systematically expand the local condom market through such collaboration. Such an expansion would exploit the dual use of condoms as protection against STIs, as well as unwanted pregnancies.

Based on data provided by DKT, the total market for condoms in the Philippines in 1999 was about 34 million pieces. About 10 million pieces were provided by DOH (using USAID donated condoms that were distributed free at public outlets); about one-half million were provided by the Family Planning Organization of the Philippines (FPOP) using supplies from International Planned Parenthood Federation (IPPF), distributed free at FPOP; about 3.5 million pieces were sold through drugstores and pharmacies (private commercial sector); and more than 20 million were accounted for by the social marketing of DKT.

. Evidence from other country programs indicates that regional social marketing of condoms for HIV/AIDS prevention has a halo effect on commercial sales. That is, as social marketed condom sales increase, so do sales of other branded condoms in the private sector. Condom sales in number of pieces seem to have been rising by an average of 10 percent each year for 10 years. The current projected annual increase over the next several years is around 15 percent. Thus, the country has the potential for a much faster expansion in condom use among the general population, which can only help increase condom use by the highest at-risk groups.

**Table 3: Sources of Condoms, 1999, (in millions of units)**

Source	Amount	Percent
DKT	20.0	58.8
DOH	10.0	29.4
Private	3.5	10.3
FPOP	0.5	1.5
Total	34.0	100

Thus, in the Philippines, it might be possible to use public sector promotion of condoms to help expand the market for socially marketed condoms. For example, public health centers could provide free samples of DKT condoms as part of a promotional campaign to get clients to switch to socially marketed and commercial condoms.

Rather than link condoms to contraceptive supply security, the long-term security of condom supplies might be better addressed another way. That would be through HIV/AIDS BCC efforts to expand the condom market for social and commercial condoms, positioning them as inexpensive, widely available, high quality, and dual protection products (protection against both STIs and unwanted pregnancies). Contraceptive security issues could then concentrate on ensuring adequate supplies of pills, IUDs, injectables, and other fertility control methods.

**c. Assist PNAC in mobilizing its partner agencies to develop a strategy on STI diagnosis and treatment.** A wide variety of sources for STI case management exist in the country. This includes social hygiene clinics of local governments; syndromic treatment at some public health units; NGO clinics supported by ASEP; and, private medical practice cultivating a clientele in venereology and STIs. Drug treatment for STIs can also be obtained directly from drugstores. ASEP piloted the Triple S (Solución Sekretong Sakit) treatment pack to replace ineffective self-medication practices that are widespread in over-the-counter STI drugs. A special approach was also tested by Family Health International (FHI), which conducted a field trial for presumptive mass treatment for STIs among at-risk groups in Angeles City. The ASEP evaluation recommended possible expansion of the Triple S and Safe Pack programs, as well as further support for STI treatment.

USAID should assist PNAC to mobilize its partner agencies to review the quality and efficacy of various options. This would also include assessing the access to adequate STI treatment by various groups at-risk, including the problems of untreated STIs and incidence of overtreatment. The result would be recommendations for policy or program interventions. In developing better options for STI treatment, links should be developed to family planning and reproductive health information and services. For example, an STI module could be developed and included in the Sentrong Sigla standards, which would automatically require health centers to adopt the module to retain their quality assurance standing. Another activity could involve developing guidelines for retooling social hygiene clinics from acting as Sanitation Code enforcers to becoming LGU centers for sexual health and the reduction of sexual health risks. An argument could be made that is a legal mandate under RA 8504. A final activity could be to identify ways to make Triple S more affordable, and, therefore, more sustainable.

**d. Assist PNAC in mobilizing its partner agencies to develop a national policy for VCT for HIV/AIDS.** USAID should also support a similar effort to assist PNAC to mobilize the appropriate partner agencies to develop policies and standards that would make VCT more widely understood and practiced, especially for returning overseas Filipino workers (OFWs), clients of sex workers, and at-risk target groups. Better VCT standards would include more careful and strict observance of legal protection of privacy rights and access to care and freedom from any form of discrimination and intimidation. This national-level work should be complemented at the local level by NGOs working with LGUs to clarify current regulations for decision-makers and assisting in correct interpretation of the regulations and monitoring of implementation.

**e. Assist PNAC to develop a Department of the Interior and Local Government (DILG) and Philippine National Police (PNP) directive on harm reduction.** The Philippine National Police should be a key partner in HIV/AIDS prevention at the local level. In some jurisdictions, the police are represented on AIDS councils and have learned that collaboration with HIV/AIDS outreach workers is more productive than confrontation. However, in many ASEP areas, the coordination among NGOs conducting outreach to most at-risk groups and police authorities has been informal and episodic. If the NGOs are to gain the confidence of these MARGs, they need police cooperation, especially in cases where clients are starting to trust the outreach workers and begin to accept such harm-reduction interventions as needle exchanges. USAID could assist PNAC to help the DILG and the PNP develop appropriate operational directives for police collaboration with NGOs that are working with most at-risk groups, especially FFSW, MSM, and IDU populations. The same local intervention, as mentioned above, would be undertaken to educate LGUs on the regulations, to promote liberal interpretation, and to monitor implementation.

## **G. Critical Assumptions**

USAID/Philippines is keenly aware of several critical assumptions upon which the current strategy is built. These include:

**Continuation of a low prevalence/slow growing epidemic and the ability to monitor changes accurately.** On the basis of data generated by the HSS, the Philippines has been categorized as a low infection/slow progression epidemic. The Mission's strategy, as well as USAID's, is predicated on the epidemic being maintained at this level. However, behavior studies have shown that many

Filipinos in the most at-risk populations engage in practices that could accelerate HIV infection rates. An acceleration of the epidemic may necessitate a rethinking of both the GOP response and the USAID strategy.

**Ongoing commitment of LGUs to sustaining current interventions.** The progress made by LGUs in the area of HIV/AIDS/STI has been significant and continues to show promise, especially given the other priorities facing LGUs. Much of the HIV/AIDS work done with the LGUs was a result of the policy and advocacy undertaken by ASEP and its NGO partners. The systems have been set up for local AIDS councils to continue to plan, support, and advocate for STI/HIV/AIDS interventions. Any decrease in the LGU commitment to conduct currently funded activities, such as HSS, would severely hamper the strategic response to HIV in the Philippines.

**No decrease in national/DOH capacity to provide at least the current level of coordination.** While decentralization has strengthened LGU capacity to undertake STI/HIV/AIDS interventions, the DOH has undergone significant changes that may affect its ability to sustain activities begun under ASEP. While the DOH commitment to coordinate HSS activities has been voiced, no formal agreements with LGUs have been negotiated. In addition, with a decrease in the number of dedicated staff for STI/HIV/AIDS surveillance in the NEC, there is a concern about the DOH ability to provide adequate and timely technical assistance to the LGUs. Finally, PNAC, which is at the center of the national, multisectoral approach to fighting the epidemic, needs to be funded and staffed adequately to be able to continue its technical and administrative leadership efforts. Any decrease in resources at the national level would jeopardize gains already made.

### **III. PERFORMANCE INDICATORS**

As part of USAID's expanded response to HIV/AIDS, the Agency has established reporting requirements for Missions in all Rapid Scale-up and Intensive Focus countries. Currently, the Philippines is classified as a Basic country receiving \$1 million or more per year and as such, will comply with the Monitoring and Reporting requirements for HIV/AIDS programs. As stated in the Guideline, Mission feels, however, that measuring HIV prevalence in ante-natal clinics (i.e., the general population) may not be needed at this time. If, based on future surveillance, MARGS show significant increases in seroprevalence, then the Mission, in consultation with the Regional Bureau, may need to reconsider this position.

The Mission does support the Government of the Philippines in conducting a national HSS and BSS systems that monitor changes in the most at-risk populations and can provide the data necessary to measure the performance indicators. The performance indicators listed below would adequately reflect the stage of the epidemic and the level of interventions supported by USAID and the national and local government programs. LGUs included in the HSS/BSS system, in particular, are the large, rapidly urbanizing or highly urbanized cities that serve as centers for education, business and entertainment, covering approximately 75% of the Philippine population. These LGUs conduct annual HIV sentinel surveillance system to monitor trends of HIV prevalence and risk behavior, and manage/sustain effective local STI/HIV/AIDS intervention in their cities.

#### **A. Strategic Objective (SO): (Impact)**

- HIV seroprevalence rates among registered female sex workers (RFSWs) in all sentinel sites (PMP, SOc)<sup>17</sup>

#### **B. IR 1: Behavior**

- Proportion of MARGs who report condom use during the last sexual intercourse at risk; and
- Number of respondents who report having shared injecting equipment during the last month.

#### **C. IR 1.1: Surveillance**

- Number of local government unit (LGU) sites implementing HIV Sentinel Surveillance (HSS) and Behavior Sentinel Surveillance (BSS) (PMP, IR1b)

#### **D. IR 1.2: Sustainability**

- Number of LGUs supporting required surveillance and prevention programs

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<sup>17</sup> Taken from Performance Monitoring Plan for SO on Desired Family Size and Improved Health Sustainably Achieved, January 24, 2002.

**E. IR 1.3: NGO Capacity**

- Number of LGU sites implementing prevention interventions for MARGs (PMP, IR1c)

**F. IR 4.2: Policy/Advocacy**

- Progress made in the establishment/development of policies for financing and improved service provision

## **IV. CROSS-CUTTING ISSUES**

### **A. Youth**

Young people, between 13 and 24, represent a high proportion of those who need to be reached by targeted prevention programs. Representing a significant proportion of the total Filipino population,<sup>18</sup> youth are at higher risk for a number of well-known reasons, including their biological, social, and economic status. Among the sex workers (SWs), men who have sex with men (MSM), and injecting drug users (IDUs), young men and women predominate. Thus, major aims of the project include: aiming condom marketing strategies at the young, ensuring that young persons find voluntary counseling and testing (VCT) and sexually transmitted infection (STI) services friendly and accessible and, most importantly, being certain that information regarding HIV/STI risk and protective behaviors is appropriate, understandable, and delivered in a manner that reaches the young.

### **B. Participation of People Living with HIV/AIDS**

USAID/Philippines recognizes the necessity of involving people living with HIV/AIDS (PLWHA) in the decision-making processes at all levels of program development, implementation, and monitoring. Through the provision of technical support for organizational and advocacy efforts, organizations representing this population will be able to mobilize and provide support to their constituencies so that PLWHA may play an important role addressing the epidemic in the Philippines.

Acting as educators and spokespersons for prevention, care and support messages not only empowers PLWHA, but serves to destigmatize the disease by reducing the social distance between those infected and those who are not. It also helps to demonstrate visibly the range of people affected by the epidemic, thereby making prevention messages more relevant and meaningful. Involvement of PLWHA also insures that care and support interventions are meeting the needs of those who are being served.

### **C. Gender and Sexuality**

Bringing a gender perspective to all of the programs is an essential element of making them effective. Men and women have different needs, perspectives, and experiences both in areas relating to HIV prevention and to care and support of those affected by HIV. Within an increased risk group, such as IDUs, the concerns of female IDUs are frequently different from those of males. For example, female IDUs are much more concerned than males with issues relating to pregnancy, childbirth, and childrearing. When a family member is infected with HIV and becomes sick, women bear the greater burden of health care, income loss, and increased workload. A common concern is managing to keep their children in school. Men typically tend to be more concerned about their health and continuing to work to support their families. Specific programs to alleviate these burdens can be developed with local partners. Thus, adapting both prevention and care and support

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<sup>18</sup> Adolescents are defined by WHO as young people 12-15, youth are those 20-24.

programs to meet the gender-specific needs of men and women would be an integral part of the project.

#### **D. Drug Use and Unsafe Sexual Behavior**

Much of the drug-related risk behavior for HIV transmission in the Philippines is actually not injecting drug use itself, but risk that stems from unprotected sex in association with other drug and alcohol use. In USAID targeted areas, USAID would support nongovernmental organizations (NGO) efforts to address this. Specifically, USAID would support capacity building of USAID-funded NGOs to address drug and alcohol use *vis-à-vis* increased HIV risk behavior.

#### **E. Stigma Reduction and Human Rights**

Key among the contextual factors that affect HIV prevention and care are the human rights environment in the country and the stigma environment at the community level. Human rights principles are laid out clearly in several United Nations (UN) documents that the Philippines has signed and ratified. These principles have already guided the national response to HIV/AIDS, especially as enshrined in the Philippines national AIDS law. They also should guide USAID/Manila assistance in that response. At the same time, at the community level, stigma (de-valuing another individual or group because of a characteristic that makes them different from the majority) forces those most vulnerable to HIV infection underground and strengthens the chain of transmission among these individuals and groups, and through them, to the rest of the community.

When a government, from the national level to the local level, recognizes and respects the rights of those who are marginalized, including PLWHA, then health providers can offer better HIV services. Respect for rights translates into more effective prevention and care.

When a local community works to lessen stigma directed at those individuals and groups that are usually most vulnerable to HIV transmission (SWs, MSM, IDUs, and others perceived by the community to be at-risk for HIV), those individuals will be less afraid to seek services. They will also be more likely to receive and internalize prevention information and messages. In the same way, when a local community works to eliminate stigma directed at PLWHA, such individuals will not only be more likely to seek appropriate care, but will be more empowered to participate in the community's HIV prevention response.

Raising awareness of human rights and lessening stigma underscore the need for a multisectoral HIV/AIDS response. The governmental, community, and individual attitude change, as well as the requisite policy change to promote it, require both health and nonhealth sector collaboration. USAID/Manila, through policy advocacy assistance to the national government, capacity building and empowerment of the most vulnerable in the communities and the promotion of the greater involvement of PLWHA, can help achieve both.

## V. BUDGET AND MANAGEMENT SUPPORT

### A. Funding

An estimated budget has been prepared. Details are in Appendix C. Table 4 is a summary of the four-year budget by IR and includes a line item for local project staff. The budget assumes an annual appropriation of about \$1.5 million, for a total of about \$6 million over the life of the project.

**Table 4: Estimated Four-year Budget**

Objectives/Activities	FY 1	FY 2	FY 3	FY 4	Total	Percent
IR 1.1: Surveillance	404,000	121,000	69,000	0	594,000	10.0
IR 1.2: Sustainability	476,000	69,000	272,000	69,000	886,000	15.0
IR 1.3: NGO capacity	825,000	735,000	766,000	342,000	2,668,000	45.0
IR 4.2: Policy/Advocacy	248,000	399,000	469,000	372,000	1,488,000	25.0
Project Staff	65,600	71,000	77,000	84,000	297,000	5.0
<b>Total</b>	<b>\$2,018,000</b>	<b>\$1,395,000</b>	<b>\$1,653,000</b>	<b>\$867,000</b>	<b>\$5,933,000</b>	<b>100</b>

This budget is based on a number of assumptions, which are summarized below.

- All project management personnel would be local. The Philippines has a large pool of competent technical and management personnel. Employing local staff would also have a significant effect on reducing overall cost.
- The project would cover 10 sites (eight AIDS Surveillance and Education Project (ASEP), plus two former ASEP). This would ensure adequate coverage for national surveillance estimates.
- There would be no expansion to the 24 Department of Health (DOH) high-risk zones. This is not necessary for national estimates; it would be expensive and would seriously affect the budget and the planned interventions. Local government units (LGUs) that are interested in adopting a surveillance system would get needed technical assistance from the National Epidemiology Center (NEC), but would have to pay the costs themselves. The POLICY project is currently working with the DOH/Philippines National AIDS Council (PNAC) to expand ASEP interventions to eight additional sites.
- There would be modest extension to some contiguous sites where there is the possibility of identifying additional at-risk MSM and IDU groups, in particular. This would average one contiguous area per site (10 more sites), but it is likely that some existing sites would expand to two or more contiguous sites while others would not expand at all.
- There would be a total of 20 NGOs in the 10 sites, an average of two per site.
- A total of 160 paid CHOWs would be employed in 20 NGOs (an average of eight per NGO). There are currently 120 CHOWS employed to cover eight sites. The required number would increase because there would be more NGOs serving more at-risk groups as well as the extension areas.
- A large number of peer educators would be recruited. They would not receive salaries, honoraria or be reimbursed for expenses. They would not be participants at the various NGO capacity development training events, however, will receive training as peer educators.

- Operating costs are estimated to be 20 percent of labor.
- Indirect costs (fringe benefits and overhead) are estimated at 20 percent of labor plus operating costs. The current overhead cost of one of the prospective implementing agencies is reported to be 12 percent.
- Financial support would be phased out in Years 3 and 4 as responsibility for surveillance and NGO services is turned over to the LGUs. The strongest LGUs are expected to take over support earlier than the weaker LGUs.
- The “project manager” would be the chief of party for the NGO capacity development component. He or she would be a technical person with project management skills and would be responsible for managing all four components. Separate managers would not be contracted for each of the four components. Short-term consultants (preferably local) would be hired to carry out the surveillance, sustainability, and policy/advocacy tasks.
- Short-term technical assistance would come from both international and local experts. Technical assistance (TA) from international consultants would be required, mostly in the first year and then gradually taken over by local consultants. The ratio of international to local TA would be about 1:4.
- Activities under the Policy IR (4.2) may be carried out under a separate procurement, but the costs would be covered by this budget.

## **B. Technical Assistance Procurement**

### *. Technical Assistance Needs*

TA would be needed in the following areas:

- **Surveillance and Research:** Conducting HIV Sentinel Surveillance (HSS) validation studies; expanding the HSS to approximately 10 contiguous areas; integrating HSS with disease surveillance systems at NEC and LGU levels (10 sites); improving the Behavioral Surveillance Survey (BSS) methodology, including developing and testing behavior, change, and communication (BCC) strategies for MSM and IDU targets; monitoring implementation of both HSS and BSS (10 sites); conducting one-time studies of other at-risk groups; and designing and testing BCC models for very hard-to-reach groups.
- **NGO Capacity Development:** Identifying, educating, and promoting behavioral change among most at-risk groups; developing institutional capacity in management; developing capacity to identify and recruit MSM and IDUs for VCT; developing BCC capacity regarding most at-risk groups; linking NGOs to condom promotion and sexually transmitted infection/family planning/reproductive health (STI/FP/RH) education and referrals; developing capacity in sensitivity training for health providers; developing contraceptive social marketing (CSM) capacity; developing and distributing BCC materials for most at-risk groups; advocating for policy changes and funding; and arranging for involvement in World AIDS Day, conferences, and study tours.
- **Sustainability:** Developing strategies for sustaining all of the elements of the ASEP package (especially surveillance, outreach, and preventive education for most at-risk groups); developing procedures for LGU absorption of most at-risk group case finding/education/services; and developing and pilot-testing LGU-NGO contracting for most at-risk groups outreach/education.

- **Policy and Advocacy:** Providing TA to PNAC in developing LGU advocacy capacity; developing a national plan for condom supply; developing a strategy on STI diagnosis and treatment; developing a national plan for VCT; and developing a directive on police response to harm reduction activities.

## **APPENDIX A: SUMMARY OF THE PROPOSED USAID FOUR-YEAR STRATEGIC PLAN**

### **A. Strategic Objective for HIV/AIDS: Improved Health Sustainably Achieved**

- Keep HIV/AIDS infections low and slow.
- Prevent infections among most at-risk groups.
- Integrate HIV/AIDS interventions into LGU and NGO programs.

### **B. The Strategy for IR 1: LGU Provision and Management of HIV/AIDS Services Strengthened**

- Improve HIV/AIDS surveillance, especially of the most at-risk populations.
- Facilitate planning for LGUs to sustain HIV/AIDS education and health services for the most-at-risk populations.
- Strengthen NGO capacity to identify and reduce the threat of HIV/AIDS among the most at-risk populations.

### **B. The Strategy for IR 4: Policy Environment and Financing for Provision of Services Improved.**

- Assist PNAC, using the mandate of RS 8504, to further strengthen implementation and local interpretation of national policies supportive of financing and delivery of HIV/AIDS prevention at local levels.

### **C. IR.1.1: Key Management Systems to Sustain Delivery Improved**

**Objective:** Improve HIV/AIDS surveillance, especially of the most at-risk populations.

- Extend surveillance and education to selected areas contiguous to ASEP sites.
- Expand HSS of FFSWs, MSM and IDUs in current sites and contiguous areas.
- Strengthen NGO capacity to identify most at-risk groups.
- Conduct one-time studies of other high-risk groups.
- Integrate HSS with ID surveillance within the NEC and LGU.
- Strengthen BSS methodology.
- Continue BSS support until transition to LGU.

### **D. IR 1.2: LGU Financing for Key Health Programs Improved**

**Objective:** Facilitate planning for LGUs to sustain HIV/AIDS education and health services for the most-at-risk populations.

- Develop a strategy to sustain prevention activities.
- Develop plans for LGUs to absorb prevention activities.
- Pilot LGU contracts with NGOs in prevention activities.

**E. IR 1.3: Performance Among Service Providers Improved**

**Objective:** Strengthen NGO capacity to identify and reduce the threat of HIV/AIDS among the most at-risk populations.

- Identify NGOs capable of reaching the most-at-risk groups (FFSWs, MSM, and IDUs), and help them build their institutional capacity.
- Provide support for NGO operations and implementation.
- Develop the capacity of the NGOs to identify and recruit most at-risk groups for voluntary counseling and testing.
- Develop the capacity of the NGOs to develop and disseminate BCC messages and materials to reduce unprotected sex and harmful practices.
- Identify and support testing of innovative models for improving BCC for the most-at-risk populations.
- Link NGO work among the most-at-risk groups to condom social marketing activities.
- Build NGO capacity to provide IEC in STI/FP/RH to at-risk groups, including referral to LGU and barangay health units.
- Strengthen NGO capacity to advocate for policy change and funding.
- Support NGOs and NGO government partner participation in regional/global conferences and HIV-focused events.

**F. IR 4.2: Appropriate Legal and Regulatory Policies to Promote Provision of Services Established**

**Objective:** Assist PNAC, using the mandate of RS 8504, to further strengthen implementation and local interpretation of national policies supportive of financing and delivery of HIV/AIDS prevention at local levels.

- Assist PNAC in mobilizing its partner agencies to plan and conduct an advocacy campaign for adoption of the ASEP package by LGUs.
- Assist PNAC in mobilizing its partner agencies to develop a national plan for condom supply security.
- Assist PNAC in mobilizing its partner agencies to develop a strategy on STI diagnosis and treatment.
- Assist PNAC in mobilizing its partner agencies to develop a national policy for VCT for HIV/AIDS.
- Assist PNAC to develop a DILG/PNP directive on harm reduction.

**APPENDIX B: CURRENT AND POTENTIAL SURVEILLANCE SITES**

ASEP originally consisted of 10 surveillance sites, later reduced to eight. Those two sites have continued to conduct surveillance activities on their own. A new locality could be structured whereby some of its most at-risk groups (FFSWs, MSM, and IDUs) would be reached by extending education and surveillance work undertaken from a neighboring base site. Such a locality might be called an extension site and would be supported under the new strategy.

A new locality could be structured like ASEP sites, which would involve the establishment of a set of structures and processes (e.g., creation of a local AIDS council, passage of a local AIDS ordinance, establishment of a local capacity for serological and behavioral surveillance, among others). Such a locality might be called an expansion site for potential development in future years. A recent study identified 24 potential new sites.<sup>20</sup>

The following is a summary of the current ASEP and extension sites. Included are the potential expansion sites although they would not be supported under the strategy at this time.

**Region 1: Ilocos** There was no ASEP site in this region. If future funding levels permit, a new expansion site might be added from this region. The best candidates are: Dagupan and Urdaneta Cities in Pangasinan, San Fernando and Bauang in La Union.

**Region 2: Cagayan Valley** There was no ASEP site in this region.

**Cordillera Administrative Region:** Baguio City was an original ASEP site, which was dropped after the first half of the project. If future funding levels permit, Baguio City might be included as an expansion site.

**Region 3: Central Luzon** Angeles City is an ASEP site and will continue to be a surveillance site under the follow-on strategy with extension sites to include the municipalities of Mabalacat and Magalang. Additional candidate expansion sites include San Fernando City and Tarlac City.

**National Capital Region** Pasay and Quezon Cities are original ASEP sites that will continue to be surveillance sites in the new strategy. Extension sites from Pasay City include Paranaque, Manila, and Makati cities. Extension sites from Quezon City include Caloocan, Marikina, and Pasig cities.

**Region 4: Southern Tagalog** There was no ASEP site in this region. If future funding levels permit, new expansion sites might be added from this region. The best candidates are Batangas City, Lucena City, and Gumaca town in Quezon.

**Region 5: Bicol** There was no ASEP site in this region. If future funding levels permit, new expansion sites might be considered in Legaspi City or Matnog town in Sorsogon.

**Region 6: Western Visayas** Iloilo City is an ASEP site and will continue to be a surveillance site under the follow-on strategy.

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<sup>20</sup> Mario Taguiwalo, et al. Assessment of Vulnerability to HIV/AIDS Infection in Selected Philippines Localities, Paper prepared for the Philippine National AIDS Council (PNAC), November 2001.

**Region 7: Central Visayas** Cebu City is an ASEP site and will be a surveillance site in the new strategy. Extension sites might include Mandaue, Lapu-Lapu and Toledo cities.

**Region 8: Eastern Visayas** There was no ASEP site in this region. If future funding levels permit, new expansion sites might be added from this region. The best candidates are Tacloban and Calbayog cities.

**Region 9: Western Mindanao** Zamboanga City is an ASEP site and will be a surveillance site in the new strategy.

**Region 10: Northern Mindanao** Cagayan de Oro City was an original ASEP site that was dropped after the first half of the project. If future funding levels permit, it could be included as an expansion site in the new strategy

**Region 11: Southern Mindanao** Davao City is an ASEP site and will be a surveillance site in the new strategy. Extension sites might include Panabo and Samal Cities and Sta. Cruz town.

**Region 12: Central Mindanao** General Santos is an ASEP site and will be continue to be a surveillance site in the new strategy. Extension sites might include Koronadal City and Polomolok town.

**Autonomous Region of Muslim Mindanao and Caraga Region:** There were no ASEP sites in these regions.

**Table 5: Current ASEP and Potential Expansion and Extension Sites**

Region/Province	ASEP sites	Potential Extensions Sites	Potential Expansion Sites
<b>Region 1: Ilocos</b>			
Pangasinan			Dagupan City
			Urdaneta City
La Union			San Fernando City
			Bauang Town
<b>Region 2: Cagayan Valley</b>			
<b>Cordillera Administrative Region</b>			
Benguet			Baguio City
<b>Region 3: Central Luzon</b>			
Pampanga	Angeles City	Mabalacat	San Fernando City
		Magalang	
Tarlac			Tarlac City
<b>National Capital Region</b>	Pasay City	Paranaque	
		Manila	
		Makati	
	Quezon City	Caloocan	
		Marikina	
		Pasig	

<b>Region 4: Southern Tagalog</b>			
Batangas			Batangas City
Quezon			Lucena City
			Gumaca Town
<b>Region 5: Bicol</b>			
Albay			Legaspi City
Sorsogon			Matnog Town
<b>Region 6: Western Visayas</b>			
Iloilo	Iloilo City		
<b>Region 7: Central Visayas</b>			
Cebu	Cebu City		Mandaue City
			Lapu-Lapu City
			Toledo City
<b>Region 8: Caraga</b>			
Leyte			Tacloban City
Western Samar			Calbayog City
<b>Region 9: Western Mindanao</b>			
Zamboanga del Sur	Zamboanga City		
<b>Region 10: Northern Mindanao</b>			
Misamis Oriental			Cagayan de Oro City
<b>Region 11: Southern Mindanao</b>			
Davao del Sur	Davao City	Panabo City	
		Samal City	
		Sta. Cruz Town	
<b>Region 12: Central Mindanao</b>			
South Cotabato	General Santos City	Koronadal City	
		Pomolok Town	
<b>Autonomous Region of Muslim Mindanao</b>			
<b>Caraga Region</b>			
<b>Total</b>	8	18	13

## APPENDIX C: HIV/AIDS Illustrative Activities 2002-2006

**Table 6: Illustrative Activities and Estimated Annual Budgets for the Strategic Plan 2002-2006**

Objectives and Activities	Technical Assistance and Other Support
<b>IR 1.1.1: Objective: To improve HIV/AIDS surveillance, especially in the most at-risk populations</b>	
1. Extend surveillance and education to selected areas contiguous to ASEP sites	Operating expenses for BSS in additional areas (10 sites)
2. Expand HSS of HRG (FFSWs, MSM, IDUs) in current sites and contiguous areas	Training on HSS methodology and best practices for DOH/Social hygiene clinic staff (20K); competency and sensitivity training for DOH/LGU on working with MSM/IDUs/FFSWs (15K)
3. Strengthen NGO capacity to identify HRG	Fund Rapid Assessment to determine number of IDUs/MSM/FFSWs in 17 sites and recommendations for site implementation (45K); training of NGO staff on conducting HSS—three regional trainings
4. Conduct one-time studies of other high-risk groups	Three studies: new most at-risk groups
5. Integrate HSS with other surveillance within the NEC/LGU	Fund outside consultant to assist w/integration TA at NEC and 10 LGUs Y 1-3
6. Strengthen BSS methodology	Fund review of BSS instrument by outside consultant for survey questions to be in-line w/global best practices (7.5K); fund studies for validation of responses and secondary analysis; training of NGO/DOH staff in best practices/conducting BSS—regional trainings
7. Continue BSS support until transition to LGU	PNAC advocacy w/LGU—see IR1.2

<b>IR 1.2.1 Facilitate planning for LGUs to sustain HIV/AIDS preventive education and health services for the most-at-risk populations.</b>	
1. Develop strategy to sustain prevention activities	TA: Outside consultant to develop strategy; workshop to adopt strategy, and conference in eight sites to promote adoption of strategy
2. Develop plans for LGUs to absorb prevention activities	TA: Outside consultant to prepare local plans; workshops at eight sites to adopt plan in Year 1 and update the plans in Year 3.
3. Pilot LGU contracts with NGO in prevention activities	TA: Outside consultant to work with three LGUs to procure NGO contracts or make LGU grants to NGO in Years 2 and 4

<b>IR1.3.1: Strengthen NGO capacity to identify and reduce the threat of HIV/AIDS among the most at-risk populations</b>	
1. Identify NGOs capable of reaching the MARP and provide institutional capacity building	Regional training workshops three times a year in Year 1 and 2, for approximately 30 NGOs; individual NGOs TA as needed
2. NGO operations and implementation	Salaries for NGO staff, including outreach workers, and admin operating costs
3. TA to NGOs to identify and recruit MARGs for VCT	Regional training workshops re how to reach and recruit MARP for VCT; one time per year each in Year 1 and Year 3 for approximately 30 NGOs; regional workshops one time a year in Year 1, Year 2, and Year 3 for VCT training ; funding of NGO events/activities in Year 1, Year 2, and Year 3
4. TA to NGOs in development and dissemination of BCC messages and materials	Regional training workshops one time a year in Year 1 for approximately 30 NGOs; budget for approximately 30 NGOs for IEC production and dissemination
5. Development and testing of innovative BCC models for very-hard-to-reach MARGs	Funding of BCC models development and testing in Year 1 and Year 3
6. TA for NGOs in CSM and funding DKT to reach MARP through NGOs	Regional training workshops one time a year in Year 1 and Year 3; funding DKT
7. TA in STI, FP, RH IEC, counseling and referral; NGO sensitization of providers	Regional training workshops one time a year in Year 1 and Year 3 for STI counseling; regional training workshops one time a year in Year 1 and Year 3 in how to sensitize STI, FP, RH service providers
8. TA to NGOs in policy advocacy	Regional training workshops one time a year in Year 1, Year 2, and Year 3 for policy advocacy
9. World AIDS Day, NGO and government study tours, NGO and government conference attendance	Funding for NGO World AIDS Day activities, NGO, and government rep study tours, and NGO and government rep conference attendance

<b>IR 4.2.1: Assist PNAC, using mandate of RA 8504, to create policy environment supportive of sustained financing and delivery of HIV/AIDS prevention</b>	
1. Plan/conduct LGU advocacy campaign for ASEP package	TA: Outside consultant to prepare advocacy plan; workshops for selected LGUs vulnerable to HIV/AIDS; training of LGU lead person on adapting the ASEP package to locality. Other support: production and printing of materials (manuals or protocols) needed for ASEP package of surveillance and education activities
2. Develop national plan for condom supply security	TA: Outside consultant to prepare plan for condom supply security; workshop on national plan condom supply security. Other support: contract with DKT to work with PNAC on government-private actions to expand condom market
3. Develop strategy on STI diagnosis and treatment	TA: Outside consultant to prepare plan to develop STI strategy; conduct study of STI diagnosis and treatment from various sources public and private; workshop on options for development of STI care for various groups; consultant to prepare technical standards on STI case management; consultant to design STI drugs social marketing with government support. Other support: production of materials on standards and protocols for STI case management; training of trainers for STI case management providers
4. Develop national plan for VCT for HIV/AIDS	TA: Outside consultant to assess VCT situation and availability; workshop on findings; consultant to develop VCT options in public and private sector; workshop to adopt the VCT strategy; consultant drafts VCT strategy for PNAC adoption. Other support: production of materials on standards and protocols for VCT; training of trainers for VCT providers
5. Prepare DILG/PNP directive on harm reduction	TA: Outside consultant to develop draft directive for police units on harm reduction; training for police officials on harm reduction; workshop on proposed directive; training of police officers from all regional commands on the directive when adopted and issued. Other support: production of materials concerning the directive.

	<b>FY1</b>	<b>FY2</b>	<b>FY3</b>	<b>FY4</b>	<b>Total</b>	<b>Percent</b>
<b>Summary</b>						
IR 1.1: Surveillance	404,000	121,000	69,000	0	<b>594,000</b>	10/0
IR 1.2: Sustainability	476,000	69,000	272,000	69,000	<b>886,000</b>	15/0
IR 1.3: NGO capacity	825,000	735,000	766,000	342,000	<b>2,668,000</b>	45.0
IR 4.2: Policy/Advocacy	248,000	399,000	469,000	372,000	<b>1,488,000</b>	25.0
Project Staff	65,000	71,000	77,000	84,000	<b>297,000</b>	5.0
<b>Total</b>	<b>\$2,018,000</b>	<b>\$1,395,000</b>	<b>\$1,653,000</b>	<b>\$867,000</b>	<b>\$5,933,000</b>	<b>100</b>

**APPENDIX D:**

**Philippines HIV/AIDS Strategic Plan 2002-2006**

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## **APPENDIX E: REFERENCE MATERIALS**

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Appendix F: Strategic Design for the Follow-on HIV/AIDS Program

**I. Background**

Two priority areas for the Mission's Special Objective (SpO1): "The Threat of HIV/AIDS and Other Selected Infectious Diseases Reduced" are aimed at preventing an explosive epidemic of HIV/AIDS and controlling other leading infectious diseases in the Philippines.

To achieve these purposes, two intermediate results have been developed under SpO1. Intermediate Result 1 (IR1), "Rapid Increase of HIV/AIDS Prevented", is aimed at preventing the rapid spread of HIV/AIDS within the Philippine population by institutionalizing public and private sector mechanisms for monitoring HIV prevalence and risk behavior and encouraging behaviors that reduce individual risk for contracting and transmitting HIV. Intermediate Result 2 (IR2), "The Capacity to Identify and Reduce the Threat of Leading Infectious Diseases is Strengthened", is aimed at reducing the burden of leading infectious diseases by establishing effective links between epidemiological surveillance systems and high-quality disease control and prevention programs and by strengthening the capacity of Local Government Units (LGU) to identify and reduce the threat of leading infectious diseases

The AIDS Surveillance and Education Project (ASEP) is the main vehicle for which activities supporting the IR1 program are implemented. Authorized in July 1992, the project supported two major components, these are: 1. Surveillance, consisting of HIV Sentinel Surveillance (HSS) and the Behavior surveillance Survey (BSS) implemented by the Department of Health, and local government partners, assisted by The World Health Organization/Western Pacific Regional Office (WHO/WPRO), and 2. Education and Policy consisting of information, education and communication (IEC) activities targeted on high-risk groups through a system of community outreach and peer education, and policy work with ASEP city governments to develop local support for key elements of surveillance and prevention. This component is implemented by Program for Appropriate Technology in Health (PATH), local nongovernmental organizations (NGOs) and ASEP-supported city governments.

An impact evaluation of the ASEP was conducted between April and May 2001 by a team of independent consultants. Overall, the evaluation found the ASEP to have been a highly successful undertaking. Viewed over eight years of implementation, ASEP has achieved its most important objectives.

**II. Rationale for New Strategy Design for HIV/AIDS Program**

The Mission's new population and health strategic objective for FY 2002–FY 2006 is being designed. This new strategic objective (SO) will integrate activities for family planning, maternal and child health, HIV/AIDS, and TB. With the new SO, there is need to review current HIV/AIDS program activities and design a new strategy integrating HIV/AIDS into the new population and health strategic objective.

### **III. Statement of Work**

To assist USAID/Philippines in the design of a new HIV/AIDS initiative that is integrated into its population and health program, a design team composed of experts will be tapped. One local expert in HIV/AIDS and one expert in Population/Health/Nutrition and USAID program. These experts will join two other AID/W HIV/AIDS experts to form a four-person team that will be responsible for developing a new design strategy for USAID support to the Philippines HIV/AIDS program.

#### **The team shall deliver the following:**

- A Strategic Plan document that will include a description how the public and private sector will contribute to the accomplishment of USAID/OPHN objectives as defined in the new SO in the Strategic Plan for 2002-2006.
- A description of activities that might best be implemented by incorporation into ongoing or planned activities within the SO.

#### **The team shall do the following tasks:**

- Review the HIV/AIDS situation in the Philippines.
- Review the USAID programs in maternal and child health and HIV/AIDS surveillance, prevention and education as described in the ASEP Report.
- Identify priority interventions for the short term (first year) and long term (three years) to address identified problems.
- Identify illustrative approaches that would likely be used in achieving the results.
- Recommend potential counterparts and their respective roles for increased collaboration with the Government of the Philippines (GOP) and other donors in the implementation of priority interventions.
- Undertake necessary mandatory analyses required by the provisions of ADS 201 (Planning).
- Estimate resource requirements over the planning period to achieve the short-term and long-term objectives.

#### **In developing the strategic plan, the team of consultants should consider the following:**

- Adequacy of resources currently available to combat HIV/AIDS, commitment and capacity of other partners, including other donors, in achieving the national objectives;

- USAID's comparative advantage in supporting the Philippines' efforts to combat HIV/AIDS in the light of the past experience with HIV/AIDS control efforts;
- Current levels of high-risk groups' knowledge, attitudes, practices, and behavior that impact on successful HIV/AIDS program implementation; and
- Sustainability of the current and planned initiatives.

## **V. Methodology**

Review of project documents and reports; interviews with key USAID personnel and program managers, key stakeholders (staff of the Department of Health [DOH], LGUs, SpO1 key implementing partners, the Philippines National AIDS Council [PNAC], local NGOs, other donors, people living with HIV/AIDS [PLWHA], target groups); and field trips to project sites.

Project documents to be reviewed include the following:

- USAID/Philippines Strategy Paper for FY 2000–FY 2004;
- SpO1 HIV/AIDS/ID Results Framework;
- SO3 IFPMCH Results Framework;
- ASEP Final Evaluation Report, May 2001; and
- Other relevant documents.

The SpO1 Results Framework and ASEP Final Evaluation report will be provided to the members of the program design team at least a week before the design process. The additional background materials will be provided at the beginning of the assignment for review in conjunction with the team planning meetings prior to the design activity proper.

The key individuals to be interviewed shall include, but not limited to the following: USAID, DOH, WHO/WPRO, PATH, Family Health International (FHI), PNAC, selected LGUs, other donors, target groups, and PLWHA. In addition to Manila, site visits will be made to Cebu, General Santos, and Angeles.

Prior to deployment in-country, team members shall review key project documents and reference materials. At the beginning of the work period, the members of the team shall spend at least one day for teambuilding, briefing with USAID officials/staff, and further studying the basic reference documents.

During this period, the team must reach agreements on specifics of the task and how to proceed and on the team members who will have lead responsibilities for the different components of this scope of work, including drafting of the report.

The team will have a team leader among them who will report to the Chief of the Office of Population, Health and Nutrition (OPHN). The other team members will report to the team leader. The team will be coordinating closely with the USAID/SpO1 team leader assigned to coordinate the program design. Schedules of meetings with USAID, DOH, key implementing partners, and PNAC

shall be coordinated/arranged with the aforementioned at USAID/Manila.

Briefings with USAID shall be undertaken by members of the review team towards the beginning of the third week. A draft report shall be submitted to the OPHN Chief towards the beginning of the third workweek, two days prior to departure from the Philippines. Data gathering and all of the report writing up to the final draft should be completed in-country.

## **VI. Team Composition and Desired Qualifications**

The design process will require two technical experts to join two PHN/USAID/W technical officers:

1. Team Leader. Team leader with at least 10 years experience with HIV/AIDS and Health and Population programming in Asia. He/She should be knowledgeable of HIV/AIDS and maternal and child health and family planning and reproductive health program planning and management, with extensive experience in designing of HIV/AIDS/health/infectious diseases programs. Excellent oral and written skills are required. (USA)

2. Local Health Systems Analyst. He/She should have at least 10 years experience in health systems management and knowledgeable of HIV/AIDS/STIs, maternal and child health and family planning and reproductive health program activities of at the national, LGU, and NGO levels in The Philippines. Excellent oral and written skills are required. (The Philippines)

3 & 4. PHN/USAID/W Technical Officers (two)

Specific duties of the team members will include the following:

### **Team Leader:**

- Oversee and facilitate strategy team's development of strategic options;
- Oversee and facilitate strategy team's setting criteria for prioritization;
- Oversee and facilitate team's writing of strategy document for each of the funding scenarios, with associated program options and issues for monitoring and evaluation;
- Complete and ensure delivery of draft of document for presentation to USAID Philippines and key partners and stakeholders before departure;
- Complete strategy document in format agreed to among USAID Philippines office, ANE Bureau, and Synergy Project; and
- Manage and administer finances for the stakeholders' workshop.

### **Local Health Systems Analyst**

- Review of the efforts so far to create effective partnerships at the central, local government and community levels in designing and implementing USAID-funded activities;
- Review of the Local Government Performance Program and Health Reform Initiative and its implications for integration of activities funded under SpO1;
- Review of the strengths and weaknesses in the flow of health information and data to local

governments;

- Facilitate, conduct and make arrangements for a one-day workshop with HIV stakeholders, including hiring local assistants and logistical arrangements attendant to the workshop; and
- Assist team leader and PHN/USAID/W team members in the preparation of the strategy document.

## **Team**

- Set criteria for, and manage, prioritization of strategic options;
- Present and discuss strategic options with key partners and stakeholders, including the PNAC, DOH, Family Health International, U.S. Centers for Disease Control & Prevention, International HIV/AIDS Alliance, PATH Philippines Foundation, and UNAIDS, WPRO/WHO and JICA;
- Review progress toward capacity building within the DOH to take over existing USAID-funded programs that will be phased out;
- Review interventions and amount of resources the government and private sector, and/or other donors are providing support in any of the USAID activity areas; and
- Review the Performance Monitoring Plan for consistency in the use of standardized indicators of USAID and UNAIDS for HIV/AIDS/STI programs that would more accurately reflect the manageable interest of the project.

## **VII. Reporting Requirements**

The Final Strategy Document report will be prepared by the team leader after receipt of USAID and other partners' comments.

The Strategy Document report with tables and annexes should not exceed 50 pages. The report format will be as follows:

- **Executive Summary:** Concisely state the most salient findings and recommendations;
- **Introduction:** State purpose, audience, and synopsis of task;
- **Background:** Present brief overview of HIV, key policies, and current situation in Philippines;
- **USAID's Assistance Approach:** Describe the USAID program strategy and activities implemented in response to the problem, target populations, and partners;
- **Findings:** Present information that includes the effectiveness and absorptive capacity of implementing partners, programming gaps/opportunities, and local capacity;
- **Conclusions/Recommendations:** Present these regarding "key issues raised in" the approved SOW;
- **Lessons Learned**
- **Issues:** Provide a list of key technical and/or administrative issues, including monitoring and evaluation;
- **Future Directions**
- **Annexes:** Use for covering evaluation methods, field visits, and interview schedules, persons

contacted, documents reviewed, tables, and scope of work.

**The report should contain the following information on the title page:**

- Title
- Author names
- Project activity number
- Contract award number
- Sponsoring USAID Office
- Contractor/grantee name

### **VIII. Logistics**

Contractor is responsible for arranging all travel, office space, secretarial/logistical support, and communications. In addition, the team leader is responsible for draft and final report development, as well as other eligible expenses associated with the completion of the program review.